

BULLETIN

AMERICAN COLLEGE OF SURGEONS



July 2001

Volume 86, Number 7

**87th Annual
Clinical Congress
Preliminary Program
New Orleans, Louisiana
October 7-12, 2001**



BULLETIN

AMERICAN COLLEGE OF SURGEONS



JULY 2001
Volume 86, Number 7

FEATURES

Patient privacy and health information confidentiality <i>Jon H. Sutton</i>	8
E-mail from Africa connects surgeon and teen <i>Sylvia D. Campbell, MD, FACS</i>	13
2001 Clinical Congress preliminary program	17
ACS Officers and Regents	32

DEPARTMENTS

From my perspective <i>Editorial by Thomas R. Russell, MD, FACS, ACS Executive Director</i>	3
FYI: STAT	5
Dateline: Washington <i>Health Policy and Advocacy Department</i>	6
Keeping current <i>An interview with Nathaniel J. Soper, MD, FACS: State-of-the-art minimally invasive surgery</i> <i>Adrienne M. Stoller</i>	36
Socioeconomic tips of the month <i>Answers to common hotline questions</i>	39
The Journal page <i>Seymour I. Schwartz, MD, FACS</i>	52

Stephen J. Regnier
Editor

Linn Meyer
*Director of
Communications*

Diane S. Schneidman
Senior Editor

Tina Woelke
Senior Production Editor

Alden H. Harken,
MD, FACS

Charles D. Mabry,
MD, FACS

Jack W. McAninch,
MD, FACS
Editorial Advisors

Bernie Kagel
Front cover design

Bernie Kagel
Back cover design

About the cover...

This year's Clinical Congress will take place October 7-12 in New Orleans, LA, where the sound of jazz music commonly fills the air, particularly in the city's French Quarter. For a preview of this year's scientific program and postgraduate courses, as well as registration information, see pages 17-31. Highlights of this year's meeting include the second presentation of Programa Hispanico, a session on the human genome and its effects on the practice of surgery, and a session on surgical robotics. As usual, the meeting will also feature a series of named lectures. (Cover photo by Jack Edwards, ©NOMCVB.)

Bulletin of the American College of Surgeons (ISSN 0002-8045) is published monthly by the American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611. It is distributed without charge to Fellows, to Associate Fellows, to participants in the Candidate Group of the American College of Surgeons, and to medical libraries. Periodicals postage paid at Chicago, IL, and additional mailing offices. POSTMASTER: Send address changes to Bulletin of the American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211.

The American College of Surgeons' headquarters is located at 633 N. Saint Clair St., Chicago, IL 60611-3211; tel. 312/202-5000, fax: 312/202-5001; e-mail: postmaster@facs.org; Website: www.facs.org. Washington, DC, office is located at 1640 Wisconsin Ave., NW, Washington, DC 20007; tel. 202/337-2701, fax 202/337-4271.

Unless specifically stated otherwise, the opinions expressed and statements made in this publication reflect the authors' personal observations and do not imply endorsement by nor official policy of the American College of Surgeons.

©2001 by the American College of Surgeons, all rights reserved. Contents may not be reproduced, stored in a retrieval system, or transmitted in any form by any means without prior written permission of the publisher.

Library of Congress number 45-49454. Printed in the USA. Publications Agreement No. 1564382.

NEWS

Dr. Fogarty receives Jacobson Award

40

Interactive Web-based program initiated in *Journal*

41

Trauma papers competition winners announced

42

A day at the Clinical Congress: Program targets minority youths *Olga Jonasson, MD, FACS*

43

Chapter Leadership Conference: Participants look to the future *Diane S. Schneidman*

47

Committee on Trauma issues call for papers

49

2002 surgical investigators conference will focus on NIH programs and policies

51

Surgeons As Educators course to be held in early 2002

51

Officers and staff of the American College of Surgeons

Officers

Harvey W. Bender, Jr., MD, FACS, *Nashville, TN*
President
Lazar J. Greenfield, MD, FACS, *Ann Arbor, MI*
First Vice-President
LaMar S. McGinnis, Jr., MD, FACS, *Atlanta, GA*
Second Vice-President
Kathryn D. Anderson, MD, FACS, *Los Angeles, CA*
Secretary
John L. Cameron, MD, FACS, *Baltimore, MD*
Treasurer
Thomas R. Russell, MD, FACS, *Chicago, IL*
Executive Director
Gay L. Vincent, CPA, *Chicago, IL*
Comptroller

Officers-Elect (Take office October 2001)

R. Scott Jones, MD, FACS, *Charlottesville, VA**
President
Kathryn D. Anderson, MD, FACS, *Los Angeles, CA*
First Vice-President
Claude H. Organ, Jr., MD, FACS, *Oakland, CA*
Second Vice-President

Board of Regents

C. James Carrico, MD, FACS, *Dallas, TX*
Chair*
Jonathan L. Meakins, MD, FACS, *Montreal, PQ*
Vice-Chair*
Harvey W. Bender, Jr., MD, FACS, *Nashville, TN**
L. D. Britt, MD, FACS, *Norfolk, VA*
William H. Coles, MD, FACS, *New Orleans, LA*
Paul E. Collicott, MD, FACS, *Lincoln, NE**
Edward M. Copeland III, MD, FACS, *Gainesville, FL**
Richard J. Finley, MD, FACS, *Vancouver, BC*
Josef E. Fischer, MD, FACS, *Cincinnati, OH*
Alden H. Harken, MD, FACS, *Denver, CO*
Gerald B. Healy, MD, FACS, *Boston, MA**
Edward R. Laws, Jr., MD, FACS, *Charlottesville, VA*
Margaret F. Longo, MD, FACS, *Hot Springs, AR*
Jack W. McAninch, MD, FACS, *San Francisco, CA*
Mary H. McGrath, MD, FACS, *Maywood, IL*
David L. Nahrwold, MD, FACS, *Chicago, IL*
John T. Preskitt, MD, FACS, *Dallas, TX*
Ronald E. Rosenthal, MD, FACS, *Wayland, MA*
Maurice J. Webb, MD, FACS, *Rochester, MN*
*Executive Committee

Board of Governors/Executive Committee

Barbara L. Bass, MD, FACS, *Baltimore, MD*
Chair
J. Patrick O'Leary, MD, FACS, *New Orleans, LA*
Vice-Chair
William F. Sasser, MD, FACS, *St. Louis, MO*
Secretary
Sylvia D. Campbell, MD, FACS, *Tampa, FL*

Timothy C. Fabian, MD, FACS, *Memphis, TN*
G. Wilkins Hubbard II, MD, FACS, *Norfolk, VA*
David S. Mulder, MD, FACS, *Montreal, PQ*

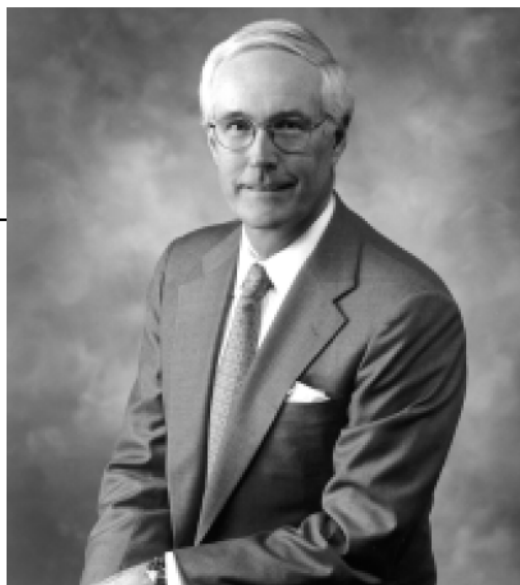
Advisory Council to the Board of Regents (Past-Presidents)

W. Gerald Austen, MD, FACS, *Boston, MA*
Henry T. Bahnson, MD, FACS, *Pittsburgh, PA*
Oliver H. Beahrs, MD, FACS, *Rochester, MN*
John M. Beal, MD, FACS, *Valdosta, GA*
George R. Dunlop, MD, FACS, *Worcester, MA*
C. Rollins Hanlon, MD, FACS, *Chicago, IL*
James D. Hardy, MD, FACS, *Madison, MS*
M. J. Jurkiewicz, MD, FACS, *Atlanta, GA*
LaSalle D. Leffall, Jr., MD, FACS, *Washington, DC*
William P. Longmire, Jr., MD, FACS, *Los Angeles, CA*
Lloyd D. MacLean, MD, FACS, *Montreal, PQ*
William H. Muller, Jr., MD, FACS, *Charlottesville, VA*
David G. Murray, MD, FACS, *Syracuse, NY*
Jonathan E. Rhoads, MD, FACS, *Philadelphia, PA*
David C. Sabiston, Jr., MD, FACS, *Durham, NC*
Seymour I. Schwartz, MD, FACS, *Rochester, NY*
George F. Sheldon, MD, FACS, *Chapel Hill, NC*
G. Tom Shires, MD, FACS, *Las Vegas, NV*
Frank C. Spencer, MD, FACS, *New York, NY*
Ralph A. Straffon, MD, FACS, *Shaker Heights, OH*
James C. Thompson, MD, FACS, *Galveston, TX*

Executive Staff

Executive Director:
Thomas R. Russell, MD, FACS
American College of Surgeons Oncology Group:
Samuel A. Wells, Jr., MD, FACS, Group Chair
Cancer Department:
Monica Morrow, MD, FACS, Director
Communications Department:
Linn Meyer, Director
Executive Services Department:
Barbara L. Dean, Director
Finance and Facilities Department:
Gay L. Vincent, CPA, Director
Health Policy and Advocacy Department:
Cynthia A. Brown, Director
Human Resources Department:
Jean DeYoung, Director
Information Services Department:
Howard Tanzman, Director
Journal of the American College of Surgeons Department:
Wendy Cowles Husser, Director
Organization Department:
John P. Lynch, Director
Surgical Education and Research Department:
Olga Jonasson, MD, FACS, Director; Gerald O. Strauch, MD, FACS, Director
Trauma Department:
Gerald O. Strauch, MD, FACS, Director
Executive Consultant:
C. Rollins Hanlon, MD, FACS

From my perspective



The American College of Surgeons is represented by a total of 99 chapters in the United States and around the world. Since I was named Executive Director of the College, I have visited 28 chapters and have come to appreciate the importance of their activities in fulfilling the overall mission of the College. The chapters have the potential to act at the grassroots level to advocate on behalf of the College's Fellows with respect to important state legislative and regulatory issues. They also can act as an information conduit to the Fellows, educating them about political issues and providing educational courses and materials.

Unfortunately, some chapters are not as active as others. As part of our overall strategic planning initiative, we need to evaluate how these potentially potent forces can be put to their best use—and how the College can help them achieve that goal.

How the chapters are organized

The first chapters were established more than 70 years ago as independent entities. In some cases, these local arms of the College were very assertive. In fact, the College sometimes had to request that chapters constrain some of their activities when they conflicted too strongly with our policies.

Today, the chapters maintain their independent status. Indeed, many have a tax status that is different from that of the College. Those that have 501(c)6 filing status are able to lobby and, if they wish, to form a separate political action committee (PAC). Additionally, the chapters have their own recruitment programs, present their own meetings, and offer their own educational opportunities.

As a result, there is no uniform model for our chapters, and great differences exist among them. For example, some chapters lack any administrative support, while others rely on sophisticated administrators who deliver management services from year to year. In some sparsely populated states, the chapters are loosely formed and very inactive. At the other end of the spectrum, a few densely populated states have up to five or six chapters. Several chapters that are active in areas encompassing multiple training programs bring surgical residents into their fold by sponsoring re-

“I believe the College must not only maintain but strengthen its chapters.”

search paper competitions and additional programs designed for the surgeon in training, while other chapters do not provide a forum of any kind for the surgeon of tomorrow. There also is disparity with respect to the relationship with the state surgical associations. Some chapters, such as the one in Virginia, work closely with the state surgical societies, while other chapters remain quite distant from other organizations.

The future of the chapters

Having broadened my knowledge of the chapters and working from the realization that many of the political policies that affect surgical practices are set at the state level (such as the residency work hours issue in New York, the credentialing of cardiac surgeons in New Jersey, and so forth), I believe the College must not only maintain but strengthen its chapters. This belief was confirmed by a recent survey of chapter presidents. More than 32 percent of the respondents feel that the College's mission for its chapters is unclear. Chapter presidents also believe their organizations should be more involved in political advocacy, the provision of continuing medical education, and patient education. To help them achieve their goals, chapter presidents say the College should offer the chapters certain services, including administrative assistance, legal advice, help with membership re-

cruitment, practice management workshops, lobbying assistance, and an expanded speakers bureau.

Overall, I do not believe that the chapters can continue to function in their current manner, and I have some thoughts about how they might become more dynamic. In the future, I believe that the chapters should unite around a common mission with sets of shared goals. This uniform mission would envelop the provision of educational opportunities for members and for local medical students and surgical residents. In addition, the chapters would function as advocates for their members and local surgical patients, paying close attention to issues of state concern and receiving input from the College's Washington Office on federal laws and rules.

Along with a unified mission, the College would set a common goal for all of the chapters each year—for instance, chapters would be encouraged to get involved in the recruitment of surgeons in all specialties. Also on an annual basis, each chapter would be expected to establish a theme for its local activities based on identified local needs.

By establishing a unified mission, a common yearly goal, and individualized themes, the chapters should become more cohesive yet still preserve their individuality.

Specific areas for growth

At this juncture, some specific areas require the chapters' attention. They are:

Recruitment: The chapters should reach out to the residency programs in their areas and encourage surgical residents to get involved in the College's activities as early as possible. The chapters also should help inspire local medical students to enter the surgical profession. To foster the chapters' involvement in the recruitment of Fellows, the College will provide enhanced opportunities for their participation on our Committees on Applicants, which exist in specific geographic areas.

Surgical education: Given the increasing emphasis on competency issues, the chapters could become an important conduit of information on how surgeons can improve and advance their skills. Indeed, the chapters could provide hands-on courses that are pertinent to the Fellowship. The College would gladly sponsor those sessions.

Public education. Through their Web sites and

other media, the chapters could be key in delivering information about appropriate surgical care to patients within their communities. These dispatches also could be used to relay information about the College and the relevance of Fellowship as a criterion for selecting a surgeon.

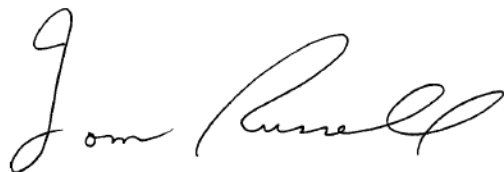
Of course, the chapters will need to be able to lean on the College in developing new programs and goals. Some services we could provide to the chapters include:

Administrative support: Some chapters are financially strong and can afford to hire local management firms to offer administrative support. For those chapters lacking these resources, the College is considering the possibility of supplying management services. For example, we could assist the chapters in the efficient coordination of their meetings, membership data base management, and educational efforts.

Speakers: The College currently has a speakers' bureau, which links the chapters with experts in various areas related to surgery. This resource might be expanded to provide appropriate speakers who are experts on the subjects encompassed within a chapter's annual theme or on the overall mission of the chapters.

Practical courses: The College currently also offers practice management and coding workshops on a regional basis and upon request to the chapters. We are considering expanding the range of practical courses on how to run an efficient office and how to collect appropriate data.

Without a doubt, there is much we can do to improve grassroots activities of all the College's domestic and international chapters. I invite each of you to send me further suggestions on how we can make our chapters stronger and more relevant in the future. Your comments and ideas are always most welcome.



Thomas R. Russell, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.

FYI: *STAT*

This column provides brief reports on important items of interest to members of the College. It will appear in the Bulletin when there is "hot news" to report. In-depth coverage of activities announced here will appear in columns and features published in the Bulletin and in the College's weekly electronic newsletter, ACS NewsScope.



The **Board of Regents held a special strategic planning retreat** as part of their June 8-10 meeting. Reports on some of the specific issues that were addressed at the meeting will be published in future issues of the *Bulletin* and *ACS NewsScope*.



The College's five delegates—LaMar McGinnis, Jr., MD, FACS; Charles Logan, MD, FACS; Richard Reiling, MD, FACS; Amilu Rothhammer, MD, FACS; and Thomas Whalen, MD, FACS—participated in the **AMA House of Delegates annual meeting**, which was held in Chicago, IL, June 17-21. In addition, Chad Rubin, MD, FACS, served as the College's delegate to the AMA's Young Physicians Section. At a meeting of the surgical caucus, David Nahrwold, MD, FACS, spoke on topics related to measuring and ensuring surgeons' competence.



In late spring, Thomas R. Russell, MD, FACS, ACS Executive Director, visited the **Virginia and Metropolitan Washington Chapters**. He also represented the College at the meeting of the **Illinois Surgical Society** and at a special board retreat held by the **Joint Commission on Accreditation of Healthcare Organizations**.



Sylvia D. Campbell, MD, FACS, a member of the Board of Governors Executive Committee and chair of the Injury Prevention and Control Subcommittee of the Committee on Trauma, represented the College at a meeting of **Doctors Against Handgun Injury** that was held in Washington, DC, on May 23. Meeting participants outlined steps for addressing the issue of firearm injury prevention from a public health perspective.



A searchable database has been created for the scientific sessions included in the **preliminary program for this year's Clinical Congress** in New Orleans. The database can be accessed at <http://www.facs.org/clincon2001/ccpreview.html>. Online registration will be available this month.



The College's **Development Program has created a traveling display** that is intended to heighten the visibility of the Fellows Leadership Society and the role of the Development Program in College activities. The display made its debut at the Spring Meeting and also was exhibited at the annual meeting of the Virginia Chapter. It is available to any chapter that would like to have a Development Program representative at its meeting. Further information is available from Fred Holzrichter via phone at 312/202-5376 or via e-mail at fholzrichter@facs.org.

Dateline|Washington

prepared by the Washington Office, Health Policy and Advocacy Department

Senate prepares to debate managed care reform

Following Sen. James Jeffords' (I-VT) decision to change his party affiliation, the new Democratic majority announced plans to expedite Senate consideration of patients' rights legislation. Two principal bills are pending in the Senate: the Bipartisan Patient Protection Act introduced by Sens. John McCain (R-AZ), Edward Kennedy (D-MA), and John Edwards (D-NC); and the Bipartisan Patients' Bill of Rights introduced by Sens. Bill Frist, MD, FACS (R-TN), John Breaux (D-LA), and Jeffords.

Both bills include managed care protections that have wide support on Capitol Hill, including a ban on "gag clauses," ensured access to specialty care, and independent external review of insurance denials. Another patient protection sought by many physician and patient groups—the right to sue health plans—is more controversial and is treated differently in the two bills. The McCain bill includes a \$5 million cap on punitive damages for health plans, while the Frist bill includes a \$500,000 cap on noneconomic damages and bans punitive damage awards. Neither bill places any limits on physician liability.

The McCain bill is very similar to the Norwood-Dingell bill that passed in the House of Representatives last congressional session. However, President Bush has publicly announced that he will veto that bill if it reaches his desk, citing the \$5 million cap on punitive damages and the absence of a noneconomic damages cap as particularly problematic. Working in consultation with a number of national medical and surgical specialty societies, including the College, Senator Frist and others drafted an alternative bill that the President has since endorsed. After some particularly objectionable sections were removed, the College sent a letter of support to Senators Frist, Jeffords, and Breaux when the new bill was formally introduced on May 15, specifically noting the critical importance of gaining President Bush's support for the effort. A follow-up letter to the Senate sponsors was sent on June 4, outlining remaining concerns with some of the bill's more technical details.

Medicare approves new coverage expansions

The Health Care Financing Administration (HCFA) announced on May 25 that Medicare coverage of liver transplants will be expanded to include certain patients with primary hepatocellular carcinoma. This will be the program's first movement towards transplant coverage for a liver malignancy. Although HCFA does not anticipate a large number of Medicare transplants for this disease, the procedure is viewed as extremely important because there are few alternative therapies for these patients. HCFA officials also said that a technology assessment would be sought for other types of malignancies in an effort to further expand coverage. Details of the May 18 decision memorandum are available at www.hcfa.gov/coverage/8b3-rr.htm.

Also of interest, Health and Human Services (HHS) Secretary Tommy Thompson announced on May 3 that Medicare will expedite coverage of pneumatic compression pumps to make it easier for Medicare patients with lymphedema to take advantage of the technology. The new coverage policy eliminates language that made these devices the treatment "of last resort" for beneficiaries suffering from the often debili-

Health plans rarely report to the NPDB

tating condition. Instead, pumps will be covered if a beneficiary first undergoes an initial therapy of conservative care that includes elevation, exercise, and the use of a compression garment for at least four weeks without results. The new policy eliminates the need for patients to purchase a more expensive, custom-made garment before becoming eligible to receive a pump. Details of the coverage decision are available at www.hcfa.gov/coverage/8b3-z.htm.

According to a report issued by the HHS Office of the Inspector General (OIG) in May, managed care organizations rarely submit reports to the National Practitioner Data Bank (NPDB) on adverse actions they take against physicians and other health professionals. Between September 1990 and September 1999, managed care plans reported a total of only 715 adverse actions to the data bank; 84 percent of plans made no reports at all. The report, *Managed Care Organizations Nonreporting to the National Practitioner Data Bank, A Signal for Broader Concern*, concluded that the two most likely causes of low reporting levels were a limited focus on clinical oversight by managed care organizations and reliance on hospitals, physician practice groups, and state licensure boards to monitor quality matters.

The report is available on the OIG's Web site at <http://www.oig.hhs.gov/oei/reports/a521.pdf>.

Many changes foreseen at HCFA

Thomas A. Scully, confirmed by the Senate as the new HCFA Administrator on May 25, and HHS Secretary Thompson recently discussed plans for implementing a variety of changes and reforms at the agency. For example:

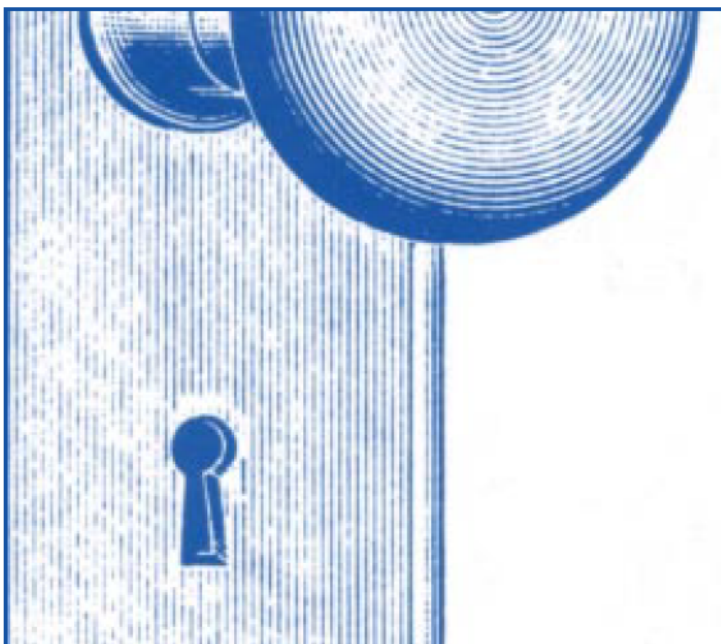
- HCFA soon will make more use of newspaper advertisements, the Internet, and toll-free telephone numbers to market Medicare program and benefits. In particular, it is reported that plans are under way to conduct an aggressive advertising campaign targeted toward enrolling 30 percent of Medicare beneficiaries in the program's managed care plans by 2005.
- HCFA staff were invited to participate in a "Rename the Agency" contest to help establish a new identity that better describes the agency's mission and responsibilities. The results were announced on June 14 by HHS Secretary Thompson, who said that HCFA will now be called the Centers for Medicare and Medicaid Services (CMS). The name change and restructuring will also allow for more effective management of Medicare's managed care and fee-for-service programs.
- Most controversial, the agency tentatively announced plans to develop new "scorecards" for every Medicare provider. Comprised of numerical ratings for a limited number of criteria, such as medical credentials, staffing levels, and patient satisfaction, the scorecards are expected to be issued four times a year. Details of the proposal are still being developed, but it is reported that nursing homes would be the first provider group to receive ratings, followed by dialysis clinics, hospitals, and physicians. Officials believe that a new rating system could not only help Medicare patients make more informed choices, but also encourage improvements in quality of care.

Patient privacy and health information confidentiality

by Jon H. Sutton, State Affairs Associate,
Health Policy and Advocacy Department

"The surgeon should maintain the confidentiality of information from and about the patient, except as such information must be communicated for the patient's proper care or as is required by law."

—American College of Surgeons
Statements on Principles,
Statement IV.D.



In recent years, a great deal of attention has been focused on the issue of patient privacy and medical records/health information confidentiality. Rapid advancements in information technology, the development of health care delivery systems with non-traditional relationships to other business entities, and the ease with which personally identifiable health information may be electronically disclosed around the globe have caused genuine concern among patient advocacy organizations, state and federal governments, and the medical profession.

Physicians have always maintained strong ethical standards and principles pertaining to privacy and confidentiality of pa-

tients' health information. These standards are considered a sacred part of the physician-patient relationship. However, while most physicians fervently adhere to this principle, business entities, third-party payors, and other elements of the health care delivery system are not as committed to preserving patient privacy and trust. Indeed, the potential uses for personal medical information have evolved over the years to encompass a broad range of goals, many of which are laudable, but some of which are troublesome. For example, patient data may be used for direct marketing of pharmaceuticals, assessing the quality of care provided by individual physicians or under various health plans, and ensuring the financial integrity of publicly financed health care systems. Patients also fear that their personal medical information may influence their employers' decisions about promotions or downsizing or be made public in press reports or civil court actions.

In response to these growing concerns, the federal government in 1996 passed the Health Insurance Portability and Accountability Act (HIPAA), and rules to implement the standards for electronic transactions were issued April 14, 2001. In addition, state legislatures have explored the issue and passed privacy of health information statutes.

This article examines the status of patient privacy and confidentiality protections in the states by describing in some detail three state laws and by briefly reviewing the HIPAA standards for electronic transactions.

State privacy statutes

Grasping the varied and complex details of each state's patient privacy and confidentiality statutes can be very difficult. For example, some states have few protections and may only restrict access to and disclosure of mental health or substance abuse records and the results of genetic testing. Many states do allow patients to access their own medical records, and, in some cases, that includes records for services provided by nonphysicians (such as optometrists and pharmacists).

In addition, the statutes are found in various places within their respective civil codes. For example, medical privacy pertaining to patient information in the possession of health maintenance organizations (HMOs) might be included in the

insurance licensing statute, and laws affecting physicians might be part of the medical licensing statute. Protection of health information might also be found in consumer protection laws, yet may only cover certain health care professionals or entities.

A central source of information on health privacy laws in the states has been collected by the Health Privacy Project, based at Georgetown University in its Institute for Health Care Research and Policy. This organization undertook an 18-month project completed in 1999 that queried all 50 states and the District of Columbia regarding their health privacy laws. The Health Privacy Project then summarized by state the data according to patient access, restrictions on disclosure, condition-specific requirements (cancer, trauma, HIV, and so on), remedies and penalties for violation of the law, government-maintained records, and research.¹ The resulting 289-page report, "The State of Health Privacy: An Uneven Terrain," is available on the project's Web site (<http://www.healthprivacy.org/resources>).

States with broad statutes

A few states—**Hawaii, Rhode Island, and Wisconsin**—have reasonably comprehensive health privacy statutes that are worth examining in greater detail.

Hawaii

The Hawaii legislature passed House Bill 351 during its 1999 session, creating the Privacy of Health Care Information Act—commonly referred to as Act 87. In the preamble of the bill, the legislature concludes that "individuals have a constitutional right to privacy with respect to their personal health information and records, and with respect to information about their medical care and health status."² These sentiments are reflected in the law's extensive provisions.

Under the provisions of Act 87, Hawaiian citizens or their "designees" have the right to inspect and copy their protected health information held by an "entity," which is defined as a health care provider, health care data organization, health plan, health oversight agency, public health authority, employer, insurer, health researcher, law enforcement official, or educational institution.

Patient requests for this information must be submitted in writing and may be denied only under limited circumstances. Physicians and other entities must post in a prominent place a notice of their current confidentiality practices, including the following information:

- A description of the individual's rights with respect to protected health information, including the right to inspect and copy his or her record, the right to request that information be appended to the medical record, and the right to receive this notice by each health plan upon enrollment, annually thereafter, and when confidentiality practices are substantially amended.
- Information about the potential uses and disclosures of protected health information authorized under state law—claims payment; quality assurance and outcomes assessments; competence or qualifications reviews; accreditation, licensing, or credentialing activities; analysis of claims or health care records data; clinical performance evaluations; utilization management; or audits.
- Explanation of the individual's right to limit disclosure of protected health information by deciding not to use any health insurance or other third-party payment and description of the procedures for giving and revoking consent to disclosures of protected health information.
- Description of procedures established by the entity for the exercise of the individual's rights required by statute.
- Documentation of the right to obtain a copy of the notice of confidentiality practices required by the statute.²

Protected health information may be disclosed for the purpose of treatment, payment, or qualified health care operations—otherwise, proper consent must be obtained. Exceptions are made for certain circumstances, such as coroner or medical examiner activities, emergency situations, public health reports and registries, and so forth. Separate authorization is not required for health research or discovery as part of a court order.

Finally, penalties are assessed to those entities that violate Act 87. For a knowing violation, a civil penalty of \$25,000 for each and every violation, not to exceed \$100,000, may be assessed. An individual may also bring a civil action against an entity that violates these privacy rights.

The Hawaii legislature suspended Act 87 in the

summer of 2000 with the intent to resolve problems raised by medical providers, hospitals, and workers' compensation insurers. In addition, there are efforts in the legislature to repeal the statute following the promulgation of national standards under HIPAA.³

Rhode Island

The Confidentiality of Health Care Communications and Information Act is contained in Title 5, Chapter 5-37, of the Rhode Island Businesses and Professions Code. A patient has the right to access his or her medical records, and a patient's confidential health care information may not be released or transferred without the written consent of the patient or the patient's authorized representative. Exceptions to the written consent requirements include:

- Physicians or other medical personnel who believe in good faith that the information is necessary for diagnosis or treatment of the individual in a medical or dental emergency.
- Review boards conducting peer review or medical/dental licensure and discipline activities.
- Qualified personnel conducting scientific research or other activities, provided no individual patient is identified in any report.
- Qualified personnel and health care providers within the medical system who share information between or among themselves in order to coordinate the patient's health care services or for education and training within the facility.
- Third-party health insurers for claims payment purposes.
- Civil or legal purposes as required by law or court order.
- Public health officials in the conduct of their functions.
- The cancer registry.

The Rhode Island statute specifically notes that, unless otherwise allowed by law, an individual's confidential health care information cannot be given, sold, transferred, or in any way relayed to another person not specified in the consent form without first obtaining the patient's additional written consent for the new use of this information. Violation of this or any part of the Confidentiality of Health Care Communications and Information Act could result in civil or criminal penalties.⁴

Wisconsin

The confidentiality of health care records for patients in Wisconsin is strongly protected. Twenty-three specified health care providers (that is, physicians, nurses, clinics, and inpatient facilities) are prohibited from disclosing patient health care records without written consent. The consent must include: (1) the patient's name, (2) the type of information to be disclosed, (3) the types of health care providers making the disclosure, and (4) the purpose of the disclosure. However, disclosure of patient health care records is permitted without written informed consent under certain circumstances, including:

- Health care facility committees, accreditation, or health care services review organizations that conduct management audits, financial audits, program monitoring and evaluation, health care services reviews, or accreditation.
- Health care providers caring for the patient, medical staff members, and employees involved in consultations, emergency situations, preparation and maintenance of records, claims, or pursuit of a lawful court order.
- Federal or state governmental agencies performing legally authorized functions.
- Researchers affiliated with the health care provider.

Individuals who knowingly and willfully violate this law are liable for actual damages to the person, exemplary damages of not more than \$25,000, and costs that include reasonable actual attorney fees. Any person, including the state or political subdivision of the state, who negligently violates the law shall be similarly liable, although exemplary damages are limited to \$1,000.⁵

HIPAA regulation

On December 28, 2000, the U.S. Department of Health and Human Services (HHS) issued national standards to ensure the confidentiality of patient medical records. First proposed in November 1999 as mandated by HIPAA, the regulations essentially serve as a "national baseline" for protection of patient medical records; states with stronger patient confidentiality laws will be allowed to maintain their own standards. While the new federal regulations became effective

Resources

American College of Surgeons

<http://www.facs.org/dept/HPA/index.html>

Select "ACS Views on Legislative, Regulatory, and Other Issues" and "Publications on Socioeconomic Issues" to find information on policies and views pertaining to patient privacy and health information confidentiality.

American Medical Association

<http://ama-assn.org/ama/pub/category/4015.html>

This page is devoted to the AMA's Washington, DC, activities and contains fact sheets and comments on the HIPAA rules. Scroll down to "The White House and Federal Agencies" and select "AMA Communications on Proposed Regulations."

Health Privacy Project

<http://www.healthprivacy.org>

Download the report "The State of Health Privacy: An Uneven Terrain," as well as other information pertaining to health privacy.

Joint Healthcare Information Technology Alliance (JHITA)

<http://www.jhita.org/admsimp.htm>

An issue summary on the HIPAA privacy standards and links to numerous resources are provided.

U.S. Department of Health and Human Services

Administrative Simplification

<http://aspe.hhs.gov/admsimp/>

Scroll down to "National Standards" to obtain a copy of the HIPAA privacy rules, as well as implementation guides and other information.

April 14, 2001, compliance will not be mandated until April 14, 2003.

The initial proposed regulations posed a variety of concerns for the surgical community, such as limiting physicians to sharing only the "minimum necessary" portion of a patient's medical records with other physicians caring for the patient. The College argued that limited informa-

tion exchange could have a negative impact on patient care and that physicians should be allowed to share all appropriate information about an individual with other physicians who are treating the patient.

The final regulation was changed to reflect this recommendation, and was issued only days before President Clinton left office. Under pressure from a variety of sources, the new Bush Administration offered the public an additional opportunity to comment on the rules. Taking advantage of that opportunity, the College offered comments on the following areas:

- *Administrative requirements.* The final rule imposes unreasonable burdens and expectations on the health care system. Surgeons and other physicians already must, under ethical and legal obligations, maintain the confidentiality of patient medical records. Adding more burdens will take time away from patient care and increase the time spent complying with administrative requirements.

- *Effect on disease registries.* Under the privacy rules, hospitals that report to the National Cancer Data Base (NCDB)—the data collection analysis arm of the American College of Surgeons Commission on Cancer—would be required to de-identify the cancer data before they are transmitted to the NCDB. Information to be stripped out would include city, county, zip code, and birth date, which are all key elements in identifying cases for subsequent study. If the NCDB were to be defined as critical to the public health, physicians and hospitals would be permitted to disclose personal health information without individual/patient authorization.

- *Private sector accreditation programs.* The College operates two approval programs: one that sets standards for cancer programs and another that assesses trauma centers (as well as burn centers in conjunction with the American Burn Center Association). Under the HIPAA privacy rules, these approval programs could be considered “business associates” and could be required to develop a formal business associate contract between them and any facility program they assess. The administrative burdens of changing this from a voluntary program to one that requires a formal contract will likely lead to increased costs that many programs may not

be able to sustain. If these accrediting organizations were defined as health oversight agencies, the need for a formal business associate contract would be eliminated.⁶

HHS Secretary Tommy Thompson has indicated the department is reviewing the comments, and he expects some changes to the privacy regulations in the near future. Currently, the regulation would apply to certain “covered entities,” which would include health plans, institutional providers, physicians and other health care professionals, and health information clearinghouses. These covered entities would have strict requirements on when they could disclose individually identifiable health information. In many cases, these protections would also apply to all business associates of the covered entities. In addition, patients would have the right to inspect and copy their medical records. Physicians must provide written notices to their patients on the potential uses and disclosures of their protected health information.

The exact nature of future changes and also how exactly the regulations will affect each state's current medical records privacy laws remains unclear.

Conclusion

Most surgeons' practices are familiar with the health information privacy requirements in their respective states and comply with them. While the final HIPAA privacy regulations have been issued, their ultimate impact on surgical practice and their relationship to current state laws is not yet known. The College will continue to monitor this situation on behalf of its Fellows and their patients. Individuals seeking further information, compliance advice, and so forth, should watch for future communications from the College. In addition, specific questions or concerns regarding state privacy laws can be raised with Jon Sutton in the College's Chicago Office at 312/202-5150, and questions regarding the federal regulations can be raised with the College's Washington Office at 202/337-2701. 

References

1. Pitts J, Goldman J, Hudson Z, et al: *The State of Health Privacy: An Uneven Terrain. A Comprehensive Review of the Current Landscape*. Chicago: American College of Surgeons, 2002. *continued on page 51*

E-mail from Africa connects surgeon and teen



From: todifa@infocom.co.ug
To: sylcamp@aol.com
Subject: Appeal for sponsorship in

I am a 15-year-old girl in Uganda
fied that I have a hole in my h
ever I carry out any tedious a
father died five years ago an
grown very thin for my age...I
distances...There is no facil
am, therefore, kindly appe
sponsor me in any way pos
save the needy.



by Sylvia D. Campbell, MD, FACS, Tampa, FL

I have never been to Africa. I have vague pictures in my mind of green forests covered in flowers, shaded by giant trees, and shrouded in mystery. Words and images from books, stories, and the ever-present world of movies and television have given me a vision of a place of beauty and excitement, tragedy and pain. Yet I have never known the reality of this continent, so far away and yet which would become in many ways so close.

Watching the miracle of Martha has opened my eyes, my heart, and my soul to this world in ways that have changed me and those around me forever. For miracles do occur. Sometimes they are so loud they shout their existence, taking us by surprise and overwhelming our senses. But sometimes, somehow, they occur so quietly, so unexpectedly, that we stand back outside them and wonder with quiet awe at what has occurred.

And so is the story of Martha Kawala. Her courage, her strength, and her faith brought her from a world across the sea to my home and my heart for all time.

Author got mail

It was the last day of the first year of the new millennium—a beautiful, warm Tampa day filled with quiet peace after the holidays. I opened my laptop to check my e-mail, expecting messages from friends and family scattered around the country. My 15-year-old daughter sat reading at my feet, and the afternoon sun touched her face.

With the onslaught of viruses found in e-mails, I was reluctant to open messages from unknown senders, afraid of somehow becoming infected. Contained in the middle of many messages was one with the address todifa@infocom.co.ug, and the subject line: Appeal for sponsorship in heart surgery. I almost didn't open the message; I almost hit the delete key. Something, however, prodded me to look inside.

And there was the message:

I am a 15-year-old girl in Uganda...Three years ago doctors identified that I have a hole in my heart...I feel pain and fatigue whenever I carry out any tedious activity...I am a total or-



Martha, preoperatively, with her Uncle Emmanuel.

phan, my father died five years ago and my mother three years ago...I have grown very thin for my age...I find it difficult to walk long distances...There is no facility for heart operation in Uganda...I am, therefore, kindly appealing for your kind consideration to sponsor me in any way possible...God bless you in your efforts to save the needy.

She had gotten my e-mail address from a doctor in her village who had read an article I had written about Haiti (*Bulletin*, October 1999), and with the hope and faith of a child, she had written to me.

How can one offer help to an orphan in Uganda? How can one person do anything to help someone known only through the world of cyberspace? How can all of the pieces come together to make open-heart surgery happen for a child on a continent so far away? How can one turn one's back to a child so in need, so in pain,

Overleaf, left: Dr. Campbell and Martha; right: Martha.

knowing that without an operation done so commonly in this country, she would die?

I knew in my heart that it would be possible to arrange for the procedure to be done, somehow, and I knew I would do all that I could to help this child.

Making the miraculous possible

Martha's problem was an atrial septal defect, and she had no signs of pulmonary hypertension. So, the problem seemed to be surgically correctable. I began asking questions about how it would get done.

I spoke with my pastor, Dr. John DeBevoise, of Palma Ceia Presbyterian Church, and he agreed we should not give up and encouraged me to try. I also spoke with Sister Pat Shirley at St. Joseph's Hospital, a Catholic institution where I work, and she told me of a program that Rotary International has known as "Gift of Life." Through this program, children from other countries, primarily in the Caribbean, have been sponsored to come to Tampa for life-saving surgery. No one had ever come from another continent, but it was worth a try. I spoke with the hospital administration, which agreed that if the program would sponsor the child, she could come to our facility. I spoke with the cardiac surgeons, and Victor Morell, MD, agreed to operate if all the conditions were favorable.

I then remembered a discussion with Mr. Dennis Viera, of Rotary International, who had talked to me about digging wells in other countries, and I contacted him for help with the Gift of Life Program. He contacted the Uganda Rotary, who agreed to help. The Uganda Rotary was unable to afford the tickets for Martha and her uncle, Emmanuel Ofumbi, to come to this country, so I again began asking for help. Pastor DeBevoise, whose congregation took Martha and her uncle in as their own, agreed to cover the cost of what we could not raise. Nurses, doctors, anesthesia personnel, and church members donated the \$3,500 necessary for the trip.

Martha and her uncle were to stay with me and become part of my family for the month that they would be here. My husband, Bob, and my three children eagerly anticipated this new addition to our family.



Martha coloring Easter eggs for the first time, with Dr. Campbell's son, Ross.

Martha's arrival

We stood at the airport—Dr. DeBevoise, Mr. Viera, and I—awaiting the arrival of Martha and Emmanuel. I wondered what Martha and her uncle must be thinking as they entered such an unknown world, what fear they must be feeling. I thought about a 15-year-old facing such unimaginable surgery, of her wondering, perhaps, if she would ever see her home again. We had only communicated by the Internet, and I had no idea who would emerge from the plane, just as they had no idea who would greet them. We waited and I was filled with hope and fear as I thought about what could happen.

Martha and Emmanuel were the last to deplane, and we had begun to worry that they would not

arrive. But as they came up the escalator and entered our world, I could not help but reflect in amazement at the events that had occurred. It was as though it was all meant to be, and I knew in my heart all would be well.

The life-saving procedure

Following a repeat echocardiogram in Tampa, Martha had her operation at St. Joseph's Hospital. I stood with her as she was brought into the operating room and was anesthetized and while all of the preparations were made for her open-heart surgery. At the time her heart was exposed, her right atrium was markedly enlarged, and she was found to have a sinus venous atrial septal defect. Using an autologous pericardial patch, Dr. Morell was able to funnel the flow of the right-sided pulmonary veins through the atrial septal defect into the left atrium, and restore her to what would be a normal life. Standing scrubbed in on the case, I watched the beauty of the dance of the cardiac surgery team, each member an integral part of a ballet that took place with form and grace.

In the pediatric cardiac surgery unit that night, Martha smiled weakly at me as I assured her that she would be fine. Her postoperative course was relatively stable, though complicated by the development of a pericardial effusion that responded to placement of a temporary catheter, which was removed when the problem had been resolved. The excellent care of the nurses and physicians resulted in a quick recovery, and she began to laugh and smile, eat some of our foods, and venture into the world of Florida that surrounded her.

A community bands together

The local Rotary Club kept her active, and she was able to spend a day with Mickey Mouse at Disney World. She attended Plant High School with my daughter Chelsey. The entire community became involved in her story, and reached out to help her in any way possible—visiting her, bringing her gifts and cards, and sharing their love.

As she stood next to the pastor in church on Palm Sunday, reading the text with self-assurance and poise, I was amazed at the journey this child had traveled and all that it had meant to so many whom she had touched. It had been such a short time from

New Year's to Easter, yet, in this time, so much had unfolded.

Martha had become part of my family, as had her Uncle Emma, and my children shall always remember this time and what it meant to us all, for this was the year that Martha came from Africa to be with us. Africa, once an unknown continent, is now made personal by the wonder and beauty of these people who had entered our lives.

Our gift

Martha has a new life now, with her heart fixed. But we are the ones who have been given the true gift, for we have been able to witness the unfolding of a miracle, and to experience the change in those around us who truly care enough to reach out a hand to an unknown orphan across the sea and be forever blessed by her beauty, her grace, and her love.

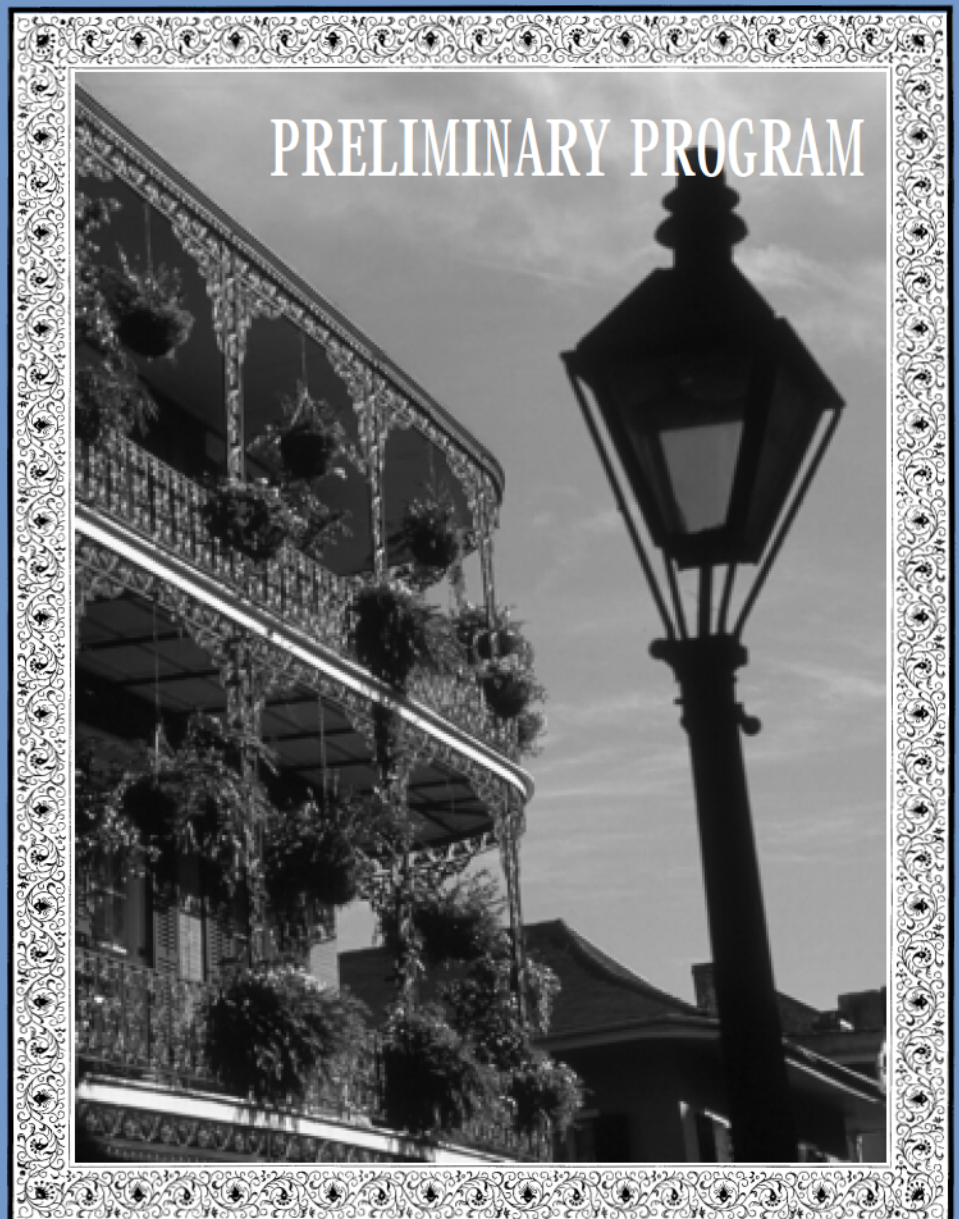
Miracles do occur each day. We are always given the opportunity to experience them, but it is up to us to see them and, in this realization, have a world opened to us that we otherwise would miss.

It is funny how this world, which seems so very large, is in reality so small. It is funny how so many of our actions continue on, even when we have left them, to touch us again and again as we travel in this journey of life. It is up to us to recognize and remember them, for we are all interconnected on this our earth.

Martha is one child in a world of so many in need. But one child is the world to those around her. For this child, and this miracle, I will be forever grateful. I have learned that impossible things do happen, if given the chance. And I will never again be afraid to try. None of us should be afraid to try. 

Dr. Campbell is a general surgeon on the staff of St. Joseph's and Tampa (FL) General Hospitals. She also is the Chair of the Subcommittee on Injury Prevention and Control, ACS Committee on Trauma. She can be reached at sylcamp@aol.com.

AMERICAN COLLEGE OF SURGEONS
87TH ANNUAL CLINICAL CONGRESS
NEW ORLEANS, LA, OCTOBER 7-12, 2001



NOMCVB, ANN PURCELL



FROM THE CHAIR, BOARD OF REGENTS COME TO THE 2001 CLINICAL CONGRESS

Dear Colleagues:

On behalf of the entire College, I extend our heartiest invitation to you to attend the 87th Annual Clinical Congress of the American College of Surgeons, which, this year, will again be held in New Orleans, LA.

The College's Program Committee has exerted another outstanding effort to bring to all of our members an aggregation of educational sessions and courses aimed at improving the surgeon's daily care of patients. As issues such as patient safety, maintenance of board certification, and the measurement of competence begin to occupy increasing attention and importance in surgical practice, it is clear that the Clinical Congress will need to bring considerations of these issues into focus, and the planning for this Clinical Congress has been undertaken in this light. An additional aspect of program planning for the Congress that has become increasingly apparent is the incorporation of evidence-based information into its scientific presentations.

A major new element planned for this year's scientific exhibits will be the presentation of major examples of state-of-the-art surgical simulation, as they currently exist. The two goals expressed for this ambitious undertaking are: (1) to display commercial simulators currently in production, as well as emerging models from academic and governmental research laboratories; and (2) to test the skill levels of experienced laparoscopic surgeons, using simulation training models in order to determine criteria for surgical skills training of surgeons in the future. After the years of anticipation by the profession for such capability to become reality, this effort promises to receive perhaps the most attention of any other single aspect of the Clinical Congress.

As always, there will be a menu of scientific offerings that will challenge your ability to experience all that you wish to see and hear. I hope you will plan to join us in New Orleans this October.

Collegially,

A handwritten signature in black ink that reads "C. James Carrico".

C. James Carrico, MD, FACS
Chair, Board of Regents

SCIENTIFIC PROGRAM REGISTRATION

American College of Surgeons
87th Annual Clinical Congress
New Orleans, LA
October 7–12, 2001

Mail to:
American College of Surgeons
Attn: Jeff Smith
PO Box 92340
Chicago, IL 60675-2340

Register online at www.facs.org

Fax to:
800/682-0252 or 312/202-5003

SPECIALTY

- ☐ SUR - General Surgery
☐ THO - Cardiothoracic Surgery
☐ CRS - Colon & Rectal Surgery
☐ OBG - Gynecology & Obstetrics
☐ NEU - Neurological Surgery
☐ OPT - Ophthalmic Surgery
☐ ORT - Orthopaedic Surgery
☐ ORL - Otorhinolaryngology
☐ PED - Pediatric Surgery
☐ PLA - Plastic & Maxillofacial Surgery
☐ URO - Urology
☐ VAS - Vascular Surgery
☐ Other: _____

► *Advance registration closes on August 13 for U.S. and Canadian registrants and on July 23 for international registrants.*

► *Do not include hotel deposit with this form. It will delay your reservation.*

► *Cancellation deadline: August 13 for U.S. and Canadian registrants and July 23 for international registrants. Refunds will not be issued after these dates.*

ACS FELLOWSHIP ID NUMBER _____

FIRST NAME AND MIDDLE INITIAL _____

LAST NAME _____

ADDRESS (NUMBER AND STREET) _____

CITY _____

STATE/PROVINCE _____

ZIP/POSTAL CODE _____

COUNTRY _____

TELEPHONE _____

FAX _____

E-MAIL _____

CATEGORY	On or Before 7/23 (international) or 8/13 (U.S./Canada)	After 7/23 (international) or 8/13 (U.S./Canada)
1 ☐ Fellow of the American College of Surgeons ...	No fee	No fee
2 ☐ Initiate	No fee	No fee
3 ☐ Associate Fellow	No fee	No fee
4 ☐ Participant in ACS Candidate Group	No fee	No fee
5 ☐ Surgical resident—with letter of verification	\$195	\$220
6 ☐ Guest physician	\$525	\$575
(U.S., Canada, international)		
7 ☐ Medical student—with letter of verification	No fee	No fee
A ☐ Hospital administrator	\$225	\$275
B ☐ Hospital or group practice purchasing agent	\$225	\$275
C ☐ Medical association personnel	\$225	\$275
D ☐ Nurse	\$225	\$275
E ☐ Physician assistant	\$225	\$275
F ☐ Technician	\$225	\$275
G ☐ Other	\$225	\$275
(Specify) _____		
H ☐ PhD	\$525	\$575
K ☐ Social program	\$ 25	\$ 50
(Name) _____		
R ☐ Commercial press	\$225	\$275
(Company name) _____		
Registration subtotal		\$ _____ \$ _____

Register Online & Save Time
www.facs.org

(Form continues on next page)

SCIENTIFIC PROGRAM REGISTRATION *(continued)*

POSTGRADUATE COURSE SELECTION

- | | | | | | |
|---------------------------------|--|-------|---------------------------------|--|---------|
| ☐ PG 1 | Image-Guided Breast Biopsy | \$250 | ☐ PG 17* | Abdominal Ultrasound: Transabdominal/
Intraoperative/Laparoscopic | \$1,000 |
| ☐ PG 2 | Ultrasound for Surgeons | \$500 | | Prerequisite: Ultrasound for Surgeons (PG2) | |
| ☐ PG 3 | Professional Liability and Risk Management
in a Changing Health Care
Environment | \$200 | ☐ PG 18 | Reimbursement for Surgeons:
Process and Practice | \$200 |
| ☐ PG 4* | Ultrasound Instructors Course | | ☐ PG 19 | Minimal Access Surgery | \$300 |
| | Prerequisite: Refer to page 23 (by application only) | | ☐ PG 20 | Clinical Update in Trauma | \$400 |
| ☐ PG 5* | Breast Ultrasound | \$500 | ☐ PG 21 | Cardiac Surgery | \$300 |
| | Prerequisite: Ultrasound for Surgeons (PG2) | | ☐ PG 22 | Laparoscopy and Urology | \$200 |
| ☐ PG 6 | Computers in Surgery—Advanced
Course | \$275 | ☐ PG 23 | Surgical Infection and Antibiotics | \$200 |
| | Workshop: (choose one) | | ☐ PG 24 | Breast Disease | \$200 |
| | ☐ A-Monday ☐ B-Wednesday ☐ C-Thursday | | ☐ PG 25 | Pre- and Postoperative Care
(Nutritional Support) | \$200 |
| ☐ PG 7 | Head and Neck Surgery | \$200 | ☐ PG 26 | Anesthetic Innovations for Improving Surgery
and Postoperative Pain Control | \$200 |
| ☐ PG 8* | Ultrasound in the Acute Setting | \$750 | ☐ PG 27 | Preview of SESAP 11 | \$300 |
| | Prerequisite: Ultrasound for Surgeons (PG2) | | ☐ PG 28* | Vascular Ultrasound | \$500 |
| ☐ PG 9 | Diseases of the Liver, Biliary Tract,
and Pancreas | \$400 | | Prerequisite: Ultrasound for Surgeons (PG 2) | |
| ☐ PG 10 | Vascular Surgery | \$300 | ☐ PG 29 | Practical Operating Room Management
for Surgeons | \$200 |
| ☐ PG 11 | Thoracic Surgery | \$400 | ☐ PG 30 | Lymphatic Mapping and the Significance
of Sentinel Node Biopsy | \$300 |
| ☐ PG 12 | Current Controversies in Cancer
Management | \$300 | ☐ PG 31 | Complex Hemangiomas and Vascular
Malformations | \$200 |
| ☐ PG 13 | Computers in Surgery—Basic Course . | \$350 | ☐ PG 32 | Perioperative Care of the Anemic
Patient | \$200 |
| | Lecture: (choose one) | | ☐ PG 33 | Surgical Education: Principles and
Practice | \$200 |
| | ☐ I-Monday am ☐ II-Monday pm | | ☐ PG 34 | Colon and Rectal Surgery | \$200 |
| | Workshop: (choose one) | | ☐ PG 35 | The Anatomy of Surgical Correction of
Groin and Abdominal Wall Hernias . | \$200 |
| | ☐ A-Tuesday am (8:30) ☐ B-Tuesday pm (1:30) | | ☐ PG 36 | Esophageal Function Testing: What the
GI Surgeon Needs to Know | \$300 |
| ☐ PG 14 | Gastrointestinal Disease | \$400 | | | |
| ☐ PG 15* | Stereotactic Breast Biopsy | \$450 | | | |
| | Prerequisite: Image-Guided Breast Biopsy (PG1) | | | | |
| ☐ PG 16* | Head and Neck Ultrasound | \$500 | | | |
| | Prerequisite: Ultrasound for Surgeons (PG2) | | | | |

PG course fee subtotal \$ _____



☐ Check here if ADA
(Americans with Disabilities Act)
accommodation is desired.
A staff person will contact you.

Please specify ☐ Audio ☐ Visual
☐ Mobile ☐ Other

* Requires prerequisite(s) for registration.
Please refer to the course descriptions on pages 22-29
for more information.

Fees payable in U.S. funds to: American College of Surgeons

☐ Check ☐ MasterCard ☐ Visa ☐ American Express

Name on card _____

Card number _____ Expiration date _____

Signature _____

Registration subtotal \$ _____

PG course fee subtotal \$ _____

Total amount \$ _____

SCIENTIFIC PROGRAM HIGHLIGHTS

As part of our mission to provide the most comprehensive educational curriculum for surgeons at the 87th Annual Clinical Congress, we offer unique programs that cover a range of current topics of profound interest to us all. The impact of these issues can result in radical changes that are often controversial. As such, these issues demand our fullest attention and complete understanding. We are, therefore, pleased to present these special subjects at the 87th Annual Clinical Congress:

SPECIAL SUBJECTS

Gastroesophageal Reflux and Achalasia: Medical versus Surgical Management

Pain Control in Outpatient Surgery

Understanding the Human Genome and How It Will Revolutionize the Practice of Surgery

Thoracoabdominal Injuries

What Every Trauma Surgeon Needs to Know About Spinal Cord Injury

Surgical Robotics or Robotic Surgery: Will It Replace or Aid Surgeons?

Programa Hispanico

Colloquium on Ethics: End-of-Life Care

Management of Incisional Hernias

Preservation and Restoration of:
—Anal Sphincter and GI Function
—Male Sexual and Urinary Function



NOMCVB, RICHARD NOWITZ

POSTGRADUATE COURSES

PG 1

Image-Guided Breast Biopsy

CHAIR: Philip Z. Israel, MD, FACS, *Marietta, GA*

4 hours

Sunday, October 7, 7:30 am–12:00 noon

Fee: \$250

The objective of this course is to teach surgeons how to identify mammographic abnormalities and recognize when additional image studies are needed. Surgeons will learn how to differentiate between benign and malignant lesions and when to recommend close follow-up as opposed to operation. Surgeons will learn how to correlate the mammographic image with the pathologic finding and to implement appropriate clinical pathways. The techniques for the performance of stereotactic biopsy and ultrasound-guided biopsy will be reviewed.

PG 2

Ultrasound for Surgeons

CHAIR: R. Stephen Smith, MD, FACS, *Wichita, KS*

4 hours

Sunday, October 7, 1:00 - 5:00 pm

Fee: \$500

The objective of this course is to provide the practicing surgeon and surgical resident with a basic core of education and training in ultrasound imaging as a foundation for specific clinical applications. The basic core module or its equivalent is a prerequisite for education in advanced training modules in the management of specific clinical problems.

The basic course is an introduction to ultrasound and does not qualify the surgeon to apply the technique independently. Successful completion of a focused module(s) will make the participant eligible for verification by the College, implying that the surgeon is "proctor-ready."

PG 3

Professional Liability and Risk Management in a Changing Health Care Environment

CO-CHAIR: Susan H. Adelman, MD, FACS, *Ann Arbor, MI*

CO-CHAIR: F. Dean Griffen, MD, FACS, *Shreveport, LA*

4 hours

Sunday, October 7, 1:00–5:30 pm

Fee: \$200



NOMCVB, CARL PURCELL

The health care delivery system in the United States has undergone dramatic changes in the past decade. Greater intervention by third-party payors into the traditional patient-physician relationship is occurring, resulting in greater risk of litigation directed against the treating physician. Attention to the new risks, as well as the traditional high-risk areas, is critical so that physicians can devote their time to the care of the patient and minimize involvement in the legal system.

The objective of this course is to review the new areas of physician liability that occur in the managed care era, including contract liability and delay and/or denial of care, as well as to identify the traditional high-risk areas of surgical practice and the importance of careful documentation in the medical record. In addition, the road map of the legal system and the perspective of plaintiff and defense attorneys will diminish anxiety about unknowns in the legal process. Methods available to deal with these risks will be discussed, including the system approach to error prevention. Proactive advice will be given on how to protect one's mental health during this process. Upon completion, participants will have learned to identify new areas of physician liability, as well as traditional high-risk areas of surgical practice. Patient safety, risk management, and risk prevention will be emphasized. Participants also will have gained an understanding of the legal process and its psychologic impact, depositions, and courtroom strategies.

PG 4

Ultrasound Instructors Course

CHAIR: M. Margaret Knudson, MD, FACS, *San Francisco, CA*

4 hours

Monday, October 8, 7:30 am–12:00 noon

Prerequisite: Approval by the National Ultrasound Faculty Vice-Chair for Education. *For additional information, e-mail Darrell Sparkman @dsparkman@facs.org.*

This course is designed to provide the experienced surgeon sonographer with the skills necessary to teach ultrasound to surgical residents at the local level and to practicing surgeons at the national level.

PG 5

Breast Ultrasound

CHAIR: Edgar D. Staren, MD, PhD, FACS, *Toledo, OH*
7 hours

Monday, October 8, 8:30 am–12:00 noon, and 1:00–5:00 pm

Fee: \$500

Prerequisite: Ultrasound for Surgeons (PG 2). *(Due to limited seating and workshop capacity, early registration is encouraged.)*

If you have not taken the ACS-sponsored prerequisite, but have taken a comparable course elsewhere, please include one of the following documents with your registration form: CME certificate, certificate of completion, registration confirmation/verification. If you do not have one of these documents, please contact the organization that sponsored the course to obtain a copy. Your registration will not be processed until your accompanying documentation has been approved by the National Ultrasound Faculty.

The objective of this course is to introduce the practicing general surgeon to a focused module in diagnostic and interventional breast ultrasound. The program will consist of lectures and hands-on skill stations using a variety of ultrasound equipment. Live model and phantom breast moulages will be used to develop skills in breast ultrasound imaging and ultrasound-guided breast biopsy.

PG 6

Computers in Surgery—Advanced Course

CHAIR: David A. Krusch, MD, FACS, *Rochester, NY*

6 hours

Workshops (choice of one):

Monday, October 8, 9:30 am–12:30 pm, and 2:00–5:30 pm

Wednesday, October 10, 8:30 am–12:00 noon, and 1:30–5:00 pm

Thursday, October 11, 7:30–11:00 am, and 11:45 am–3:15 pm

Fee: \$275

The objective of this course is to provide the advanced computer user with instruction in effective Medline searching techniques using the National Library of Medicine's PubMed, managing citations using EndNote for manuscript preparation and information retrieval, creating a successful scientific presentation using PowerPoint, manipulating images electronically for publication and presentation, improving presentation skills, and an introduction to publishing presentations on the Web. This course is designed to enhance the ability of a junior faculty member in the presentation and publication of scientific material in all forms: printed,

audience presentations, and Web publications. As a prerequisite, attendees should have prior knowledge of basic computer concepts. This six-hour course will be presented in its entirety in a workshop format and does not include a lecture component.

PG 7

Head and Neck Surgery

CHAIR: Ashok R. Shaha, MD, FACS, *New York, NY*

6 hours

Monday, October 8, 9:30 am–12:30 pm, and 1:30–5:30 pm

Fee: \$200

The surgery of mostly malignant disease of the head and neck, as well as some complicated benign variants, will be presented to the participants. A number of techniques are new to this area, as are the results of multimodal therapy. At the conclusion of the course, the participants should be familiar with the up-to-date nuances in head and neck surgery.

PG 8

Ultrasound in the Acute Setting

CHAIR: Heidi L. Frankel, MD, FACS, *New Haven, CT*

6 hours

Monday, October 8, 12:30–6:30 pm

Fee: \$750

Prerequisite: Ultrasound for Surgeons (PG 2). *(Due to limited seating and workshop capacity, early registration is encouraged.)*

If you have not taken the ACS-sponsored prerequisite but have taken a comparable course elsewhere, please include one of the following documents with your registration form: CME certificate, certificate of completion, registration confirmation/verification. If you do not have one of these documents, please contact the organization that sponsored the course to obtain a copy. Your registration will not be processed until your accompanying documentation has been approved by the National Ultrasound Faculty.

The objective of this course is to familiarize the participant with areas of ultrasound frequency used by general surgeons to evaluate patients with acute surgical problems. The participant will learn how to conduct focused ultrasound examinations through individual hands-on experience and will acquire an understanding of the essentials of ultrasound technology and physics.

PG 9

Diseases of the Liver, Biliary Tract, and Pancreas

CHAIR: Alexander S. Rosemurgy II, MD, FACS, *Tampa, FL*

12 hours

Monday, October 8, 1:30–5:00 pm; Tuesday–Thursday, October 9–11, 8:30 am–12:00 noon

Fee: \$400

The objective of this course is to update participants on the etiology, pathophysiology, diagnosis, and treatment, both surgical and nonsurgical, of patients with diseases of the liver, biliary tract, and pancreas. A number of new innovations in the area, especially in diagnostics and therapeutics, as well as the evolution of surgical operations in this complicated area, will be presented. A multidisciplinary approach that includes medicine, surgery, radiology, and other subspecialties will be used.

PG 10

Vascular Surgery

CHAIR: William M. Abbott, MD, FACS, *Boston, MA*

6 hours

Monday–Tuesday, October 8–9, 1:30–5:00 pm

Fee: \$300

The objective of this course is to review the newest diagnostic and therapeutic treatment methods for vascular problems in current vascular surgery practice. The overall theme is new approaches to old problems.

PG 11

Thoracic Surgery

CHAIR: Douglas E. Wood, MD, *Seattle, WA*

12 hours

Monday–Wednesday, October 8–10, 1:30–5:00 pm, and Thursday, October 11, 1:00–3:00 pm

Fee: \$400

The objective of this course is to provide a comprehensive overview of pulmonary, esophageal, and mediastinal surgery.

PG 12

Current Controversies in Cancer Management

Co-CHAIR: Miguel A. Rodriguez-Bigas, MD, FACS, *New York, NY*

Co-CHAIR: Lawrence D. Wagman, MD, FACS, *Duarte, CA*
9 hours
Monday–Wednesday, October 8–10, 1:30–5:00 pm
Fee: \$300

There are presently many controversies as well as advances in cancer care. Some of these clinical problems are commonly seen in clinical practice. The objectives of this course are to: (1) discuss clinical controversies in cancer care, (2) introduce new imaging and diagnostic modalities in the care of the cancer patient, and (3) introduce potential areas of future investigation in controversial areas of cancer care.

PG 13

Computers in Surgery—Basic Course

CHAIR: David A. Krusch, MD, FACS, *Rochester, NY*
6 hours
Lectures (choice of one):
Monday, October 8, 9:30 am–12:30 pm
Monday, October 8, 2:00–5:30 pm
Workshops (choice of one):
Tuesday, October 9, 8:30 am–12:00 noon
Tuesday, October 9, 1:30–5:00 pm
Fee: \$350

The objective of this course is to teach basic PC techniques to the beginning user. A lecture series and a hands-on workshop will provide the practicing surgeon with a practical, working knowledge of current concepts. The course content will include an introduction to basic PC hardware and concepts, types and methods of Internet connectivity, remote access to clinical data, medical knowledge-based searching techniques, and medical resources available on the Internet. Upon successful completion of the course, participants should be able to choose appropriate personal computers and use the Internet to increase professional productivity.

PG 14

Gastrointestinal Disease

CHAIR: Sean J. Mulvihill, MD, FACS, *Salt Lake City, UT*
12 hours
Monday–Wednesday, October 8–10, 1:30–5:00 pm, and
Thursday, October 11, 1:00–3:00 pm
Fee: \$400

The objective of this course is to familiarize participants with contemporary approaches to gastrointestinal diseases of interest to the general surgeon. Patho-

physiology, diagnosis, and management of specific disorders will be reviewed, with an emphasis on controversies and new advances. The course is intended to be of value to practicing general surgeons and surgical residents.

PG 15

Stereotactic Breast Biopsy

CHAIR: Darius S. Francescatti, MD, FACS, *Chicago, IL*
8 hours
Wednesday, October 10, 7:30 am–12:00 noon, and 1:00–5:30 pm
Fee: \$450
Prerequisite: Image-Guided Breast Biopsy (PG 1).

The objective of this course is to introduce the surgeon to the principles and practice of stereotactic biopsy as a minimal access means of obtaining tissue samples for diagnosing indeterminate or suspicious mammographic lesions. An overview of radiation safety issues as related to stereotaxis, as well as the technical efficacy and cost analysis of stereotactic versus other alternatives, will be presented.

PG 16

Head and Neck Ultrasound

CHAIR: Jay K. Harness, MD, FACS, *Oakland, CA*
8 hours
Tuesday, October 9, 7:30 am–12:00 noon, and 1:00–5:30 pm
Fee: \$500

Prerequisite: Ultrasound for Surgeons (PG 2). (*Due to limited seating and workshop capacity, early registration is encouraged.*)

If you have not taken the ACS-sponsored prerequisite, but have taken a comparable course elsewhere, please include one of the following documents with your registration form: CME certificate, certificate of completion, registration confirmation/verification. If you do not have one of these documents, please contact the organization that sponsored the course to obtain a copy. Your registration will not be processed until your accompanying documentation has been approved by the National Ultrasound Faculty.

The objective of this course is to provide the practicing surgeon with knowledge and practical skills in the application of diagnostic and interventional head and neck ultrasound. The program will consist of lectures

and hands-on skill stations using a variety of ultrasound equipment. Live model and phantom moulages will be used to develop skills in head and neck ultrasound imaging and ultrasound-guided head and neck biopsy.

PG 17

Abdominal Ultrasound: Transabdominal/Intraoperative/Laparoscopic

CHAIR: Junji Machi, MD, PhD, FACS, *Honolulu, HI*
12 hours

Tuesday, October 9, 7:30 am–12:00 noon, and 1:00–5:00 pm; Wednesday, October 10, 7:30 am–12:00 noon
Fee: \$1,000

Prerequisite: Ultrasound for Surgeons (PG 2). *(Due to limited seating and workshop capacity, early registration is encouraged.)*

If you have not taken the ACS-sponsored prerequisite but have taken a comparable course elsewhere, please include one of the following documents with your registration form: CME certificate, certificate of completion, registration confirmation/verification. If you do not have one of these documents, please contact the organization that sponsored the course to obtain a copy. Your registration will not be processed until your accompanying documentation has been approved by the National Ultrasound Faculty.

The objective of this course is to provide the practicing surgeon and surgical resident with advanced education and training in abdominal ultrasound, including transabdominal, intraoperative, and laparoscopic ultrasound, as it is used in the diagnosis and treatment of abdominal diseases. This 1½-day course will consist of lectures and individual hands-on sessions. Human model, live animal, excised liver, and phantom will be used to develop skills in abdominal ultrasound imaging and ultrasound-guided procedure.

PG 18

Reimbursement for Surgeons: Process and Practice

CHAIR: Karen R. Borman, MD, FACS, *Jackson, MS*
6 hours

Tuesday, October 9, 8:00 am–11:30 am, and 1:00–4:30 pm
Fee: \$200

This course is intended for surgeons of all specialties. The components of the reimbursement process affecting all surgeons (for example, ICD, CPT, CCI) will

be discussed. Practical approaches to optimal reimbursement will be presented.

PG 19

Minimal Access Surgery

CHAIR: Edward H. Phillips, MD, FACS, *Los Angeles, CA*
6 hours

Tuesday–Wednesday, October 9–10, 8:30 am–12:00 noon
Fee: \$300

Minimal access surgery has revolutionized and revitalized general surgery. The extent and range of minimal access surgery has been expanded over the past five years, although a number of controversial areas remain. The participant will learn various techniques in minimal access surgery, as well as the results of various randomized prospective trials providing evidence of the importance of this new modality. Contemporary controversies, such as minimal access surgery for large and small bowel, including neoplastic disease, will be discussed.

PG 20

Clinical Update in Trauma

CHAIR: Andrew B. Peitzman, MD, FACS, *Pittsburgh, PA*
12 hours

Tuesday–Thursday, October 9–11, 8:30 am–12:00 noon, and Thursday, October 11, 1:00–3:00 pm
Fee: \$400

This course will concentrate on the management of clinical care of the trauma patient. The major areas to be covered will include changing management schemes in trauma care, controversial and novel treatments in the intensive care unit, operative management of the difficult/impossible injury, and discussion of unresolved issues in trauma care. Discussion about managing specific cases will facilitate understanding of the issues and principles.

PG 21

Cardiac Surgery

CHAIR: David A. Fullerton, MD, FACS, *Chicago, IL*
9 hours

Tuesday–Thursday, October 9–11, 8:30 am–12:00 noon
Fee: \$300

The objective of this course is to provide practicing cardiac surgeons and residents in training with current information on new techniques for myocardial

revascularization, as well as outcomes of contemporary surgical strategies for valvular heart disease.

PG 22

Laparoscopy and Urology

CHAIR: David M. Albala, MD, FACS, *Maywood, IL*

6 hours

Tuesday–Wednesday, October 9–10, 8:30 am–12:00 noon

Fee: \$200

Basic laparoscopic principles and their applications to urology will be reviewed. Applications include adrenalectomy, nephrectomy, and nephroureterectomy, in addition to new developments such as radical prostatectomy.

PG 23

Surgical Infection and Antibiotics

CHAIR: Nicolas V. Christou, MD, FACS, *Montreal, PQ*

6 hours

Tuesday–Wednesday, October 9–10, 8:30 am–12:00 noon

Fee: \$200

The proliferation of antibiotics and their various specificities have made infectious disease a surgical subspecialty over the past 20 to 30 years. This course provides an excellent review of the mechanisms of antibiotic effects on various organisms, as well as the data concerning contemporary use of antibiotics in surgery, both prophylactically and therapeutically.

PG 24

Breast Disease

CHAIR: Maureen T. Kavanah, MD, FACS, *Boston, MA*

6 hours

Tuesday–Wednesday, October 9–10, 8:30 am–12:00 noon

Fee: \$200

Breast disease has been among the most extensively studied areas of disease over the past two decades, and knowledge about it has increased proportionately. As studies from the National Surgical Adjuvant Breast and Bowel Project and others and randomized prospective trials have come to fruition, the degree of specificity in dealing with breast disease has become astounding. The participants will become familiar with the various combinations and permutations in the treatment of malignant and near-malignant disease, as well as the results of various randomized trials and of established and

newer therapies. The management of the patient at high risk for breast cancer will also be discussed.

PG 25

Pre- and Postoperative Care (Nutritional Support)

CHAIR: Frederick A. Moore, MD, FACS, *Houston, TX*

6 hours

Tuesday, October 9, 8:30 am–12:00 noon, and 1:30–5:00 pm

Fee: \$200

Nutritional support is essential for the care of the surgical patient and has been the subject of several postgraduate courses in the past. However, several years have passed since the subject was last presented—at that time, in a comprehensive 12-hour course. The intent of this year's course is to present a "current practice" approach in a more compact format, to update participants about trends in management. Relevant underlying science will be provided as necessary to put new concepts in perspective.

PG 26

Anesthetic Innovations for Improving Surgery and Postoperative Pain Control

CHAIR: Nelson H. Goldberg, MD, FACS, *Baltimore, MD*

6 hours

Tuesday–Wednesday, October 9–10, 8:30 am–12:00 noon

Fee: \$200

With the increasing pressure to perform outpatient procedures, new anesthetic agents aimed at quicker recovery, decreased nausea, and more effective pain control are evolving. The objective of this course is to review the most efficacious combinations of general, regional, and local anesthetics available for each particular operation. Specialized areas include hernia repair, facial cosmetic, upper extremity, suction-assisted lipectomy, breast surgery, and lower extremity pediatric operations. The pharmacologic specifics and advantages of the preferred agents will be clearly delineated so that surgeons might understand and actively participate in making choices for their patients.

PG 27

Preview of SESAP 11

CHAIR: Ward O. Griffen, MD, FACS, *Frankfort, MI*

9 hours

Tuesday–Wednesday, October 9–10, 8:30 am–12:00 noon, and Tuesday, October 9, 1:30–5:00 pm
Fee: \$300

The American Board of Surgery and the American College of Surgeons have issued a joint statement indicating that the Surgical Education and Self-Assessment Program (SESAP) is an important factor in continuing education for practicing general surgeons. Not only will SESAP help a surgeon to keep up-to-date and prepare for recertification, but it can be used to obtain Category 1 continuing medical education (CME) credits. Most states require some form of CME credit, so a surgeon joining in the SESAP experience can get double rewards.

Join some of the authors of SESAP 11 in a three-session pretest of this endeavor. As in the past, we will be using an interactive technology to preview the SESAP items. The audience will be able to indicate their answer by pushing a button at their seats. The audience participation results will be shown, after which the answer as determined by the SESAP Committee will be shown. One of the panelists will then discuss the item, showing more recent evidence to support the correct answer or other material pertinent to the item content. You will then have an opportunity to express your opinion.

PG 28

Vascular Ultrasound

CHAIR: David B. Pilcher, MD, RVT, FACS, *Burlington, VT*
8 hours

Wednesday, October 10, 7:30 am–12:00 noon, and 1:00–5:30 pm

Fee: \$500

Prerequisite: Ultrasound for Surgeons (PG 2). *(Due to limited seating and workshop capacity, early registration is encouraged.)*

If you have not taken the ACS-sponsored prerequisite, but have taken a comparable course elsewhere, please include one of the following documents with your registration form: CME certificate, certificate of completion, registration confirmation/verification. If you do not have one of these documents, please contact the organization that sponsored the course to obtain a copy. Your registration will not be processed until your accompanying documentation has been approved by the National Ultrasound Faculty.

The objective of this course is to provide the practicing surgeon and surgical resident with core education and training in the indications, techniques, advantages,

and limitations of ultrasound examinations in the diagnosis and evaluation of patients with vascular diseases. Emphasis will be given to those procedures that require surgeon participation in image acquisition, such as intraoperative ultrasound. The surgeon should be able to obtain optimal images to improve therapy and direct treatment in the operative arena.

PG 29

Practical Operating Room Management for Surgeons

CHAIR: Jeffrey E. Doty, MD, FACS, *San Jose, CA*

6 hours

Tuesday, October 9, 1:30–5:00 pm, and Wednesday, October 10, 8:30 am–12:00 noon

Fee: \$200

This six-hour course will provide an overview of critical issues in OR management. Experts will cover four areas from the perspective of management skills: (1) managing people, (2) managing time and information, (3) regulations, and (4) economics and the OR environment. Participants will return to their institutions and practices with new perspectives and practical skills to assist them in managing their ORs.

PG 30

Lymphatic Mapping and the Significance of Sentinel Node Biopsy

CHAIR: Armando E. Giuliano, MD, FACS, *Santa Monica, CA*

8 hours

Wednesday, October 10, 8:00 am–12:00 noon, and 1:00–5:00 pm

Fee: \$300

The objective of this course is to teach basic intellectual and practical aspects of sentinel lymph node dissection.

PG 31

Complex Hemangiomas and Vascular Malformations

CHAIR: Steven J. Fishman, MD, FACS, *Boston, MA*

6 hours

Wednesday, October 10, 8:30 am–12:00 noon, and 1:30–5:00 pm

Fee: \$200

The objective of this course is to familiarize the pedi-

atric surgeon with new scientific information and management approaches for children affected by a spectrum of complex vascular malformations. This course will outline the pathophysiology and diagnostic approaches, as well as nonoperative and operative treatment options and outcomes.

PG 32

Perioperative Care of the Anemic Patient

CO-CHAIR: Lena M. Napolitano, MD, FACS, *Baltimore, MD*

CO-CHAIR: Philip S. Barie, MD, FACS, *New York, NY*

6 hours

Wednesday, October 10, 8:30 am–12:00 noon, and 1:30–5:00 pm

Fee: \$200

The objective of this course is to review the current management of perioperative care of the anemic patient, stressing strategies to optimize the patient preoperatively, minimize blood loss intraoperatively, and implement protocols intended to reduce blood use perioperatively. The risks and benefits of anemia and blood transfusion also will be reviewed. An audience interactive system will be used to allow participants to express their opinions and to respond to questions.

PG 33

Surgical Education: Principles and Practice

CO-CHAIR: Mary E. Maniscalco-Theberge, MD, FACS, *Reston, VA*

CO-CHAIR: Michael R. Marohn, DO, FACS, *Alexandria, VA*

6 hours

Wednesday, October 10, 8:30 am–12:00 noon, and 2:00–5:00 pm

Fee: \$200

The objective of this course is to enhance the teaching skills of surgeons active in student and/or resident teaching. The principles of adult learning, needs assessment, question and feedback skills, and performance evaluation will be reviewed. In addition, participants will develop a thorough understanding of the practical applications of these principles, both in and out of the operating room.

PG 34

Colon and Rectal Surgery

CHAIR: David E. Beck, MD, FACS, *New Orleans, LA*

6 hours

Wednesday, October 10, 1:30–5:00 pm, and Thursday, October 11, 8:30 am–12:00 noon

Fee: \$200

The objective of this course is to provide an update on the management of common anorectal disease, colorectal neoplasms, bowel obstruction, and acute colorectal diseases.

PG 35

The Anatomy and Surgical Correction of Groin and Abdominal Wall Hernias

CHAIR: R. Benton Adkins, Jr., MD, FACS, *Nashville, TN*

6 hours

Thursday, October 11, 7:45–11:00 am, and 12:00 noon–3:15 pm

Fee: \$200

The objective of this course is to present basic anatomy, embryology, and variations of the abdominal wall, inguinal region, and groin. The emphasis will be on concepts, teaching, classic surgical approaches, and new technology in hernia repair. Pitfalls and admonitions for the practicing surgeon will be stressed in a classroom atmosphere.

PG 36

Esophageal Function Testing: What the GI Surgeon Needs to Know

CHAIR: Tom R. DeMeester, MD, FACS, *Los Angeles, CA*

2½ hours

Thursday, October 11, 8:30–11:30 am

Fee: \$300

At the conclusion of the course, attendees should: (1) understand the apparatus requirements and costs of setting up an esophageal motility laboratory, (2) know the essentials of performing the test and the computer analysis of the test, (3) be able to recognize the named motility disorders, (4) be able to interpret abnormalities of the lower esophageal sphincter and understand the surgical significance of a defective sphincter, and (5) be able to understand and interpret cricopharyngeal sphincter abnormalities.

GENERAL INFORMATION

Advance registration is encouraged and open to all physicians and individuals in the health care field. Please use one of the following registration options:

By Internet—Register online at: www.facs.org under "Clinical Congress." Download forms from www.facs.org under "Clinical Congress."

By mail—Complete the registration form (on pages 19-20) and mail to: American College of Surgeons, Attn: Jeff Smith, Registration Coordinator, P.O. Box 92340, Chicago, IL 60675-2340.

By fax—When paying by credit card, complete the form and fax it to: 800/682-0252 or 312/202-5003.

Payment of applicable fees must accompany the registration form. All fees are payable in U.S. dollars.

To receive a Program Planner, call 800/329-7833 (fax-back) and reference document number 0323, access the College's Web site (www.facs.org), or phone 312/202-5200.

International registrations (other than Canada) must be received by July 23. U.S. and Canadian registrations must be received by August 13. Payment of registration, postgraduate course, and social program fees must accompany your registration form. Visa, MasterCard, and American Express payment will be accepted. Registrations received and postmarked after the deadline will be billed according to the pricing structure listed under Registration Fees and Credentials, below.

Advance registrants will receive a name badge, attendance verification card, and postgraduate course ticket(s). Postgraduate course syllabus(i) will be distributed on-site at the Ernest N. Morial Convention Center.

Cancellation: Fees for registration, postgraduate course(s), and social program events will be refunded if a written request is postmarked no later than July 23 from international registrants or August 13 by U.S. and Canadian registrants. A \$50 handling fee will be charged.

REGISTRATION FEES AND CREDENTIALS

Category	On or before 7/23 or 8/13	After 7/23 or 8/13
ACS Fellow 2000 dues paid	No fee	No fee
2000 dues delinquent (U.S.)	\$375	\$375
2000 dues delinquent (Canada)	\$320	\$320
2000 dues delinquent (international)	\$155	\$155
Associate Fellow, Initiate, and ACS Candidate Group Participant	No fee	No fee



NOMCVB, RICHARD NOWITZ

Category	On or before 7/23 or 8/13	After 7/23 or 8/13
Surgical resident (Letter signed by appropriate medical director)	\$195	\$220
Guest physician (U.S., Canada, international)	\$525	\$575
Medical student (letter signed by appropriate medical director)	No fee	No fee
PhD	\$525	\$575
Allied health care personnel	\$225	\$275
Commercial press	\$225	\$275

INITIATES REGISTRATION

All Initiates will be preregistered. Return the registration form only to purchase postgraduate course tickets.

POSTGRADUATE COURSES AND FEES

Course tickets may be purchased only by registered meeting attendees. Because of limited seating capacities, advance registration is encouraged. All courses require a ticket for admission. A complete listing of courses begins on page 22.

Tickets may be exchanged until course starting time at the Ernest N. Morial Convention Center, registration area. Exchanges can only be accommodated on-site.

ACCREDITATION

The American College of Surgeons is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

CME CREDIT

The American College of Surgeons designates this educational activity for up to a maximum of 48 hours in Category 1 credit toward the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

SPOUSES and YOUNG ADULTS

Spouses, guests, and young adults (16 years and older) who want to attend College functions must pay

the nonrefundable \$50 fee. Spouses and guests who are physicians must register as physicians to receive CME credit.

CHILDREN

The ACS policy regarding children is as follows:

Under 12—not permitted on social program tours

Under 16—not permitted on exhibit floor

16 and over—must have a badge to enter exhibit area or meeting rooms

This policy includes infants in strollers and arms. Child care services are not available this year.

ANNUAL MEETING/CONVOCATION

The Annual Meeting of Fellows and Initiates will take place on Thursday, October 11, at 4:00 pm. The Convocation will begin at 8:00 pm, Thursday. Both events will be in the Ernest N. Morial Convention Center.

REGISTRATION LOCATION AND HOURS

Registration is located at Ernest N. Morial Convention Center during the following hours:

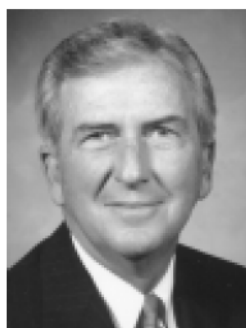
Sunday, October 7	10:00 am–6:00 pm
Monday, October 8	7:00 am–5:00 pm
Tuesday, October 9	7:00 am–5:00 pm
Wednesday, October 10	7:00 am–5:00 pm
Thursday, October 11	7:00 am–5:00 pm

Advance registration only will be held at the Hilton Riverside during the following hours:

Sunday, October 7	10:00 am–8:00 pm
-------------------------	------------------

ACS Officers and Regents

Officers/Officers-Elect

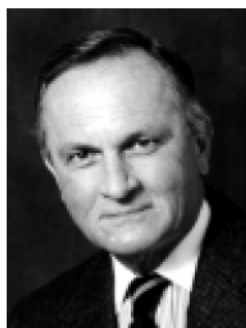


Harvey W. Bender, Jr.
President

Thoracic surgery
Professor and chair,
department of cardiac and
thoracic surgery,
The Vanderbilt Clinic
Nashville, TN

Lazar J. Greenfield
First Vice-President

Vascular surgery
Frederick A. Collier Distinguished Professor and
chairman,
department of surgery,
University of Michigan, Ann
Arbor
Ann Arbor, MI



LaMar S. McGinnis
Second Vice-President

General surgery
Medical director,
Eberhart Cancer Center,
clinical professor of surgery,
Emory University Medical
Center
Atlanta, GA

John L. Cameron
Treasurer

General surgery
Professor and chair,
department of surgery,
The Johns Hopkins
University School of Medicine
Baltimore, MD



R. Scott Jones
President-Elect

General surgery
S. Hurt Watts Professor and
chair, department of surgery,
University of Virginia Health
System
Charlottesville, VA

Kathryn D. Anderson
First Vice-President-

Elect/Secretary
Pediatric surgery
Chief and vice-president
of surgery, Children's
Hospital of Los Angeles,
professor of surgery,
University of Southern
California
Los Angeles, CA



Claude H. Organ, Jr.
Second Vice-President-
Elect

General surgery
Chair, surgery residency
program, professor, depart-
ment of surgery, University
of California, Davis-East Bay
Oakland, CA

Board of Regents

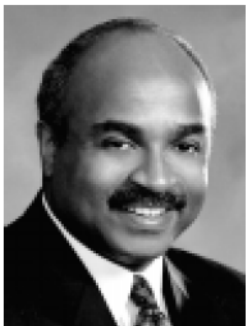


C. James Carrico
Chair

Trauma and critical care
Doris and Bryan Wildenthal
Distinguished Chair in
Medical Science and
professor,
department of surgery,
University of Texas
Southwestern Medical
Center
Dallas, TX

Jonathan L. Meakins
Vice-Chair

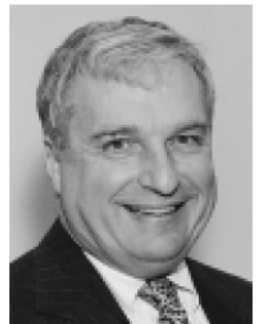
General surgery
E. W. Archibald Professor
of Surgery,
chair, McGill University,
chief, surgical services,
McGill University Health
Centre
Montreal, PQ



L. D. Britt

General surgery
Brickhouse Professor and
chair, department of surgery,
Eastern Virginia Medical
School
Norfolk, VA

William H. Coles
Ophthalmic surgery
Professor emeritus,
State University of New York
New Orleans, LA



Paul E. Collicott

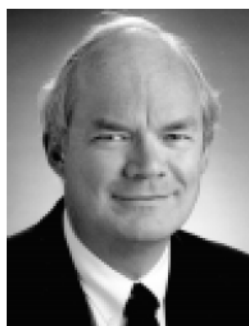
Vascular surgery
Private practice
Lincoln, NE

Edward M. Copeland III

General surgery
Edward R. Woodard
Professor and chairman,
department of surgery,
University of Florida College
of Medicine
Gainesville, FL



Board of Regents (continued)



Richard J. Finley
General surgery
C. N. Woodward Chair in
Surgery; professor and head,
department of surgery,
University of British Colum-
bia Faculty of Medicine
Vancouver, BC

Josef E. Fischer
General surgery
Professor and chairman,
department of surgery,
and associate dean,
community affairs,
University of Cincinnati
Cincinnati, OH



Alden H. Harken
Cardiothoracic surgery
Professor and chairman,
department of surgery,
University of Colorado
Denver, CO

Gerald B. Healy
Otorhinolaryngology
Otolaryngologist-in-chief,
Children's Hospital
Boston, MA



Edward R. Laws, Jr.
Neurosurgery
Professor of neurosurgery
and medicine,
University of Virginia
Health Sciences Center
Charlottesville, VA

Margaret F. Longo
General surgery
Hot Springs, AR



Board of Regents (continued)



Jack W. McAninch
Urology
Professor of urology,
University of California-
San Francisco, chief of
urology, San Francisco
General Hospital
San Francisco, CA

Mary H. McGrath
Plastic surgery
Chief, department of plastic
surgery, Loyola University
Medical Center
Maywood, IL



David L. Nahrwold
General surgery
Emeritus Professor of
Surgery,
Northwestern University
Medical School
Chicago, IL

John T. Preskitt
General surgery
Attending surgeon, Baylor
University Medical Center
Dallas, TX



Ronald E. Rosenthal
Orthopaedic surgery
Wayland, MA

Maurice J. Webb
Gynecology (oncology)
Professor and chair,
division of gynecologic
surgery,
Mayo Clinic
Rochester, MN



Keeping current

An interview with Nathaniel J. Soper, MD, FACS

State-of-the-art minimally invasive surgery

by Adrienne M. Stoller, New York, NY

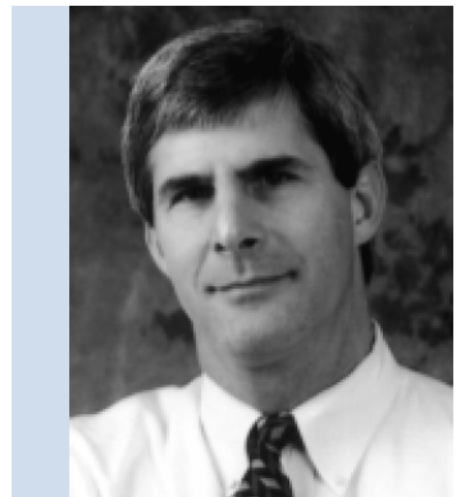
Editor's note: Nathaniel J. Soper, MD, FACS, is professor of surgery and head of minimally invasive surgery at Washington University School of Medicine in St. Louis, MO. He is past-president of the Society of American Gastrointestinal Endoscopic Surgeons (SAGES) and a member of the editorial board of ACS Surgery: Principles and Practice (formerly Scientific American® Surgery).*

Minimally invasive surgery has changed surgical practice and has given patients more treatment options. In this interview, Dr. Soper discusses current uses and new advances in minimally invasive surgery, including clinical developments, novel procedures, and technologies.

Q. What is the impetus for the development of minimally invasive procedures?

A. "Diseases that harm call for treatments that harm less." I believe this quote from Sir William Osler represents the basis for the development of minimally invasive surgery. Using minimally invasive techniques, we have learned that we can greatly reduce access trauma, the primary cause of the pain and disability related to traditional surgery. Minimally invasive techniques also decrease the degree to which a patient's immune system is suppressed, thereby reducing the rate of infection and potentially improving outcomes for patients with cancer. With these procedures, patients can now expect a shorter hospital stay, a less painful convalescence, and a rapid return to full activity.

*Scientific American® and Scientific American® Surgery are trademarks of Scientific American, Inc., and are used by WebMD Corporation under license from Scientific American, Inc.



Dr. Soper

Q. Which minimally invasive surgical procedures are commonly performed worldwide?

A. Minimally invasive procedures are a global phenomenon. The majority of operations are being done for benign disease. Primary considerations include performing the operation in a way that most favorably affects hospital costs and the patient's quality of life. Worldwide, cholecystectomy is still the most common laparoscopic procedure. Other common laparoscopic operations include appendectomy, herniorrhaphy, antireflux surgery, splenectomy, and nephrectomy. Judging from international meetings and interactions with many surgeons from around the world, the devel-

oped countries are all on an equal level in terms of advancing procedures and technology.

Q. How critical is training for minimally invasive procedures?

A. Adequate training is critical for the safe performance of minimally invasive surgery. Training for minimally invasive surgery began in the private practice sector with many surgeons from academic medical centers learning on their own or through course work. Today, general surgery residents leave their training with sound experience in basic laparoscopic operations; they also have some experience with more advanced procedures, though not as much. In general, when you're learning new procedures and applying new technologies, there is a steep learning curve. Much more time is needed to perform the first few operations, and many surgeons find they are squeezed for time because of the sheer volume of operations they perform every day, making the learning process even more challenging.

Q. What are the most significant recent advances in laparoscopic and minimally invasive procedures?

A. A few areas have seen large increases in volume. Minimally invasive surgery to prevent gastroesophageal reflux is an example. The number of patients undergoing this procedure has increased by a factor of five to six over the past 10 years as a result of the laparoscopic approach. At one time, surgery for esophageal reflux required a major thoracotomy or laparotomy. Thus, very few patients underwent antireflux surgery. Now many surgeons are performing a lot of these operations laparoscopically. Other areas that have shown a marked increase are laparoscopic incisional hernia repairs and laparoscopic colon resection. Although outcome studies for some of these procedures are pending, the decrease in morbidity for some of these operations is driving their rising performance.

Laparoscopic surgery for morbid obesity is another growing area. In fact, the number of these cases will mushroom over the next few years. Only recently have medical providers and insurers become convinced that gastric bypass surgery is ef-

fective; in large part, this has been due to a recent National Institutes of Health study showing the advantage of this procedure for people with obesity. These findings, combined with the ability to perform these operations with relatively new minimally invasive techniques (that is, laparoscopic gastric bypass), have led to an increase in the volume of these operations performed in the U.S.

Q. How about technological advances?

A. Robotics will have a large influence in surgery over the coming decades. Particularly in cardiac surgery, robotics has the potential of making a huge impact because the surgeon can achieve a very still field of view and can perform very precise, fine movements in small spaces. What its influence will be on general surgery is uncertain, because the surgeon must work within larger areas. However, given the capabilities for improved precision, robotics could open the door to new operations that could not be done with traditional techniques. Robotics will likely have a much larger impact on the performance of cardiac surgery, perhaps eliminating the morbidity of the sternotomy and heart-lung machine.

Many advances are being made in the design and production of instruments that allow safe division and hemostasis of structures during laparoscopic procedures. Thermal devices are being devised to allow minimally invasive ablation of parenchymal tumors. Non-laparoscopic minimally invasive procedures also are coming into their own. These procedures include endoluminal techniques for arterial disease and gastroesophageal reflux, precise parathyroid surgery, and radio-guided surgery.

Q. What is the most controversial issue pertaining to minimally invasive surgery?

A. The use of laparoscopy to cure malignant disease is a subject of intense debate. When performing curative operations, it is unclear whether laparoscopy is beneficial for cancer treatment. Some evidence suggests that the pneumoperitoneum itself can disseminate tumor cells and cause problems. On the other hand, early data suggest that with the decreased immunosuppression that

accompanies laparoscopic surgery, cancer-free survival may be improved through this type of procedure. I tend to believe that as long as surgeons use good traditional cancer techniques, and as long as the procedures can be done laparoscopically with less trauma to the body, minimally invasive surgery is probably a better approach to treating malignant disease. However, the results of prospective randomized trials are necessary to settle this issue.

Q. Are there common pitfalls or particular challenges in minimally invasive surgery that you would want your fellow surgeons to be aware of?

A. Intelligent case selection and training are two very important considerations. Surgeons should not start with difficult cases because it can lead to problems. Second, when embarking on a new procedure, it is wise to have some additional training in that particular area, to observe another surgeon performing the procedure, and to have an experienced surgeon serve as a proctor in the operating room. Moreover, the basic fundamentals of laparoscopic surgery need to be understood clearly. Many surgeons have learned techniques simply by doing them without fully understanding laparoscopic physiology. Thus, if a problem occurs, the surgeon will not know how to troubleshoot.

Other pitfalls include the limitations of laparoscopy itself. When the surgeon does not have a tactile sense of what is going on in the abdomen and is not 100 percent certain of the anatomy, he must be ready to convert to traditional surgery. Elective conversion is not a complication, and the decision to convert should not be influenced by one's ego. We must always remember that the first rule is "do no harm."

Q. What is on the horizon for minimally invasive procedures?

A. Robotics is a major area of investigation and development that will affect surgical procedures tremendously. In addition, virtual reality may evolve as an influential element of training and planning procedures. This technique may also be used to assess the competence of surgeons in a manner similar to the use of simulators by airline pilots. I also believe that more endoluminal techniques will surface—in particular, endoluminal techniques for treating esophageal reflux disease. Surgeons need to keep in mind that flexible gastrointestinal endoscopy is still an important part of their practices.

Within the next 10 years, I believe that 75 to 80 percent of operations on the abdominal cavity will be done using some combination of minimally invasive techniques. The only areas that will remain difficult or impossible will be major organ transplantations, surgery in patients who have had multiple operations, and other complex situations. What was once a revolutionary approach to surgery is becoming the standard for how many procedures will be done. 

ACS Surgery is pleased to introduce new chapters in minimally invasive procedures, including adrenalectomy and laparoscopic cholecystectomy. For the latest medical news and topics in surgery, log onto WebMD® at www.webmd.com.

Ms. Stoller is editor/writer, division of physician communication, WebMD, New York, NY.

Socioeconomic tips of the month

Answers to common hotline questions

This month's column focuses on various coding scenarios that are frequently the subject of inquiries from surgical practices that call the College's coding hotline.

Removal of G-tubes

The CPT manual does not contain a code that accurately describes removal of a G-tube. When a G-tube is removed in the operating room, the unlisted code 43999 should be reported. Also, because an unlisted code is being reported, the claim should be submitted on paper and be accompanied by a copy of the operative report describing the service performed. If the G-tube is removed in the office or at the bedside in the hospital, the service is considered part of any evaluation and management service that is provided.

Codes 11040-11044 versus 97601-97602

Codes 97601 and 97602 were added to CPT to describe active wound care management performed by nonphysician professionals acting within the scope of their licenses. These codes should be reported when physicians assistants, nurse practitioners, wound care nurses, physical therapists, and so on perform either selective or nonselective debridement on wounds.

CPT codes 11040-11044 describe surgical debridement performed by surgeons. These codes should be reported (rather than 97601 and 97602) when a surgeon performs an excisional debridement.

If, for example, a patient presents with necrotic tissue on the left thigh and the physician debrides the area from the skin to the subcutaneous tissue, code 11042—Debridement; skin, and subcutaneous tissue—would be reported. As the guidelines indicate in the CPT book, it is inappropriate to report codes 11040-11044 in addition to codes 97601 or 97602.

Colonoscopy for colonic tattooing

Following a separate encounter in which the physician removed a polyp, the patient returns

All specific references to CPT terminology and phraseology are: CPT only © 2000 American Medical Association. All rights reserved.

for colonic tattooing—that is, injection of dye through a sclerosing needle into the stalk of the previously removed polyp. In this situation, the unlisted code 45999 would be reported. If, however, the physician performs a colonoscopy with or without collection of specimen(s) by brushing or washing, with or without colon decompression and colonic tattooing, then the diagnostic colonoscopy code 45378 would be reported. If the physician believes there was increased work involved due to the colonic tattooing, modifier -22 may be appended to code 45378. When appending modifier -22, however, a note should be included that describes the increased work.

Laparoscopic umbilical hernia repair

CPT does contain some hernia repair codes performed by laparoscopy; however, these codes are for initial and recurrent inguinal hernia repairs. CPT does not contain a specific code that describes laparoscopic umbilical hernia repair. Therefore, the unlisted laparoscopy code 49659 should be reported for this service. It is important to remember that it is inappropriate to report a code that describes an open repair when the service was performed laparoscopically.

Again, when reporting an unlisted code such as 49659, the claim should be submitted on paper and a copy of the operative report describing the service performed should be included. 

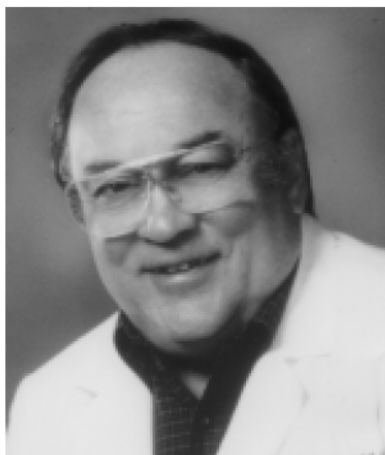
This column responds to questions from the Fellows and their staffs, and provides useful tips for surgical practices. Developed by the College staff and consultants, this information will be accessible on our Web site for easy retrieval and future access. If there are topics that you would like to see addressed in future columns, please contact the Health Policy and Advocacy Department by fax at 202/337-4271, or e-mail HealthPolicyAdvocacy@facs.org.

Dr. Fogarty receives Jacobson Award

Thomas J. Fogarty, MD, FACS, became the seventh recipient of the Jacobson Innovation Award of the American College of Surgeons during a ceremony on June 9, 2001, at the College's John B. Murphy Memorial Auditorium in Chicago, IL.

Initiated in 1994, the award honors living surgeons, or surgical teams, who have been innovative in the development of a new technique in any field of surgery. The award is made possible through a donation from Julius H. Jacobson II, MD, FACS, a general vascular surgeon known for his pioneering work in the development of microsurgery. Dr. Jacobson is director emeritus and distinguished professor of surgery at the Mount Sinai School of Medicine of the City University of New York.

Dr. Fogarty was selected for this year's award because of his pioneering, innovative, and entrepreneurial work in the development of the "industry standard" Fogarty® balloon embolectomy catheter, along with his ongoing improvement on earlier designs, which have created a more aggressive approach for this minimally invasive instrumentation. Dr. Fogarty is further honored for his more than 65 surgical instrumentation patents and management of several medical device companies founded upon his product designs. His efforts have proven to be major contributors to science and medicine throughout the world.



Dr. Fogarty

Dr. Fogarty, who currently resides in Portola Valley, CA, received his BS degree in biology from Xavier University, Cincinnati, OH, in 1956, and attended medical school at the University of Cincinnati College of Medicine, from which he received his MD degree in 1960.

After medical school, Dr. Fogarty relocated to the University of Oregon Medical School, Portland, completing his general surgery training and cardiothoracic training. During his time at the University of Oregon, he was appointed clinical associate at the National Heart Institute, Surgery Branch, at Bethesda, MD, where he worked from 1965 to 1967. He then returned to Oregon where he was instructor in surgery from 1967 to 1968. In 1969, he moved to Stanford University where he was chief resident and instruc-

tor in surgery, as well as an advanced research fellow in the division of cardiovascular surgery. He remained at Stanford on the volunteer faculty (serving as president of the medical staff from 1973 to 1978), and established a private practice of cardiovascular surgery that was extremely successful. After many years in private practice, Dr. Fogarty returned to Stanford University as professor of surgery in July 1993, where he remains at this time.

Throughout his career, Dr. Fogarty has maintained an active clinical practice and is a member of all the prominent organizations in the cardiovascular surgical field. He has served on several editorial boards and as president of the Society for Vascular Surgery. He is the president-elect of the International Society of Endovascular Specialists. In addition to his professional activities in clinical and academic surgery, Dr. Fogarty has continued a very innovative career in surgical instrumentation. While not all of Dr. Fogarty's patents have been in the field of medicine, he has had enormous impact in medicine through his technologic advances, beginning with the patent in 1969 of his first balloon catheter for peripheral embolectomy. That single contribution has had enormous influence in surgery, not only cardiovascular surgery but other fields of surgery as well. With continued improvement on Dr. Fogarty's early designs, more

aggressive catheters have been developed to remove adherent blood clots from native vessels and grafts. His interest led to the development of a number of devices used in laparoscopic hernia repairs and later to a minimally invasive device for breast cancer diagnosis and therapy.

Dr. Fogarty received the 1980 Inventor of the Year Award from the San Francisco Patent and Trademark Association, an honorary doctorate from Xavier University in 1987, a Distinguished Alumnus Award from the University of Cincinnati Medical School in 1989, the Ernst & Young Northern California 1998 Entrepreneur of the Year Award, and the Lemelson-MIT \$500,000 Prize for Inven-

tion and Innovation in May 2000.

It is most appropriate that an innovator in the area of vascular surgery be designated as the recipient of the Jacobson Innovation Award. The award is sponsored by an individual who made great contributions to instrumentation in microvascular surgery. Dr. Fogarty has changed the way surgery is practiced in the management of not only patients with vascular disease but a number of other diseases as well.

The Jacobson Innovation Award is administered by the Honors Committee of the American College of Surgeons. Recipients are selected based on the demonstration of original

thought in combination with the first presentation of work that has led to a milestone in the advancement of surgical care.

Previous recipients of the Jacobson Innovation Award are: Francois Dubois, MD (1994, laparoscopic cholecystectomy); Thomas E. Starzl, MD, FACS (1995, liver transplantation); Joel D. Cooper, MD, FACS (1996, lung transplantation and lung volume reduction surgery); Juan Carlos Parodi, MD (1998, treatment of arterial aneurysms, occlusive disease, and vascular injuries using endovascular stented grafts); John F. Burke, MD, FACS (1999, burn care); and Paul L. Tessier, MD, FACS(Hon) (2000, craniofacial surgery).

Interactive Web-based program initiated in *Journal*

Each issue of the *Journal of the American College of Surgeons (JACS)* provides subscribers and Fellows with the opportunity to earn CME-1 credits. By accessing the Web-based JACS program at <http://www.jacscme.facs.org> participants can select one or all of the four articles highlighted for the chosen month. The online, interactive program is an ACS member benefit; Fellows use their ACS ID number to access the site and subscribers use the subscriber number. There are two possible CME-1 credits per issue on the

Web site (24 total/year).

Each issue of the print copy of JACS contains two questions per month, the full text of the articles selected from the current month of publication, the learning objectives, five response choices to each question, and a critique accompanying each question. Fellows can read the full text of two questions in the print copy each month and submit responses using a fax form in the *Journal*, and receive documentation for their CME credits by return fax.

The Web site will retain a 12-

month supply of questions at all times; individual participant's scores will be maintained, and documentation of CME credit will be e-mailed to participants on a regular basis. As Editor-in-Chief Seymour I. Schwartz, MD, FACS, wrote in his editorial comment in the January 2001 *Bulletin*, "The addition of the potential for readers to acquire CME-1 credits expeditiously speaks to the College's credo to continually disseminate current information to the surgical universe and to its mission to maintain the standards of patient care."

Trauma papers competition winners announced

The ACS Committee on Trauma announced the winners of the 2001 Residents' Trauma Papers Competition at its annual meeting March 8-10 in Tampa, FL. This year, 13 regional winners received prize money of \$500, with additional first-place prize money of \$1,000 and second-place prize money of \$500. All prize money was awarded through the generosity of General Motors Research and Development. The papers competition also was funded by the Eastern and Western States Committees on Trauma and Region VII, which encompasses Iowa, Kansas, Missouri, and Nebraska.

The Residents Trauma Papers Competition is open to surgical residents and trauma fellows in the U.S., Canada, and Latin America. Papers are submitted to the individual state or provincial chair. Winning papers are selected and sent to each region chief so they can conduct the regional competition. Papers describe original research in the area of trauma care and/or prevention categorized in either basic laboratory research or clinical investigation.

Winning papers from 13 regions were presented at the Scientific Session of the Committee on Trauma Meeting, and the final four winners were announced at the Trauma Banquet. L.D. Britt, MD, FACS,



Left to right: Dr. Veri, Dr. Liberman, Dr. Soni, Dr. Hitt, and Dr. Britt.

Chair of the Regional Committees on Trauma and an ACS Regent, served as moderator.

Following is a list of the 2001 award winners:

First Place, Basic Laboratory Research: Deepa Soni, MSC, MD, Boston, MA: Induced Central Nervous System Axon Regeneration after Spinal Cord Injury.

First Place, Clinical Investigation: John-Paul Veri, BSc, MSc, MDCM, Vancouver, BC: Bicondylar Tibial Plateau Fractures: A Randomized Pro-

spective Multi-Center Trial Comparing AO and Ring Fixator Methods: Early Complication Rates.

Second Place, Basic Laboratory Research: Daron C. Hitt, MD, Oklahoma City, OK: Construction and Characterization of a Gene Therapy Vector with Implications in Fracture Healing.

Second Place, Clinical Investigation: Moishe Liberman, MD, Montreal, PQ: Multi-Centre Canadian Study of Pre-Hospital Trauma Care.

A day at the Clinical Congress

Program targets minority youths

by Olga Jonasson, MD, FACS, Director, Surgical Education and Research Department

The American College of Surgeons conducts a survey each year of residents enrolled in accredited programs for all of the surgical specialties. The most recent Longitudinal Study of Surgery Residents* provides some sobering demographic information about surgery residents—our future surgeons. Only 4.7 percent of all surgery residents who graduated in 1996 were of African-American ethnicity, and 4.5 percent are Hispanic.

The College's Graduate Medical Education Committee believes that the increasingly diverse ethnic population of the United States is best served by physicians who are aware of and sensitive to the cultural and language differences among their patients. It is, therefore, important that the profession succeed in attracting qualified students from all ethnic groups. While there may be many reasons why surgery fails to attract one group or another, we suspect that lack of information about the medical profession and a lack of access to role models in surgery are significant factors.

Subcommittee responds

The Graduate Medical Education Committee considers the



Ronda Henry-Tillman, MD, Associate Fellow (far right), Oscar Salvatierra, Jr., MD, FACS (second from right), and their students.



Kim Lattimore, MD, ACS Candidate and Associate Society member (left), and her students.

Chicago Mathematics, Science, and Technology Academies

- | | |
|---|-----------------------------------|
| — Richard Crane Technical Preparation Common School | — Paul Robeson High School |
| — John Marshall Harlan Community Academy | — Lakeview High School |
| — Christian Fenger Academy | — Theodore Roosevelt High School |
| — Wendell Phillips Academy | — Benito Juarez Community Academy |
| — Roberto Clemente High School | — South Shore Community Academy |

* Kwakwa F, Jonasson O: The longitudinal study of surgical residents, 1994 to 1996. *J Am Coll Surg*, 188:575-585, 1999.

underrepresentation among African-American and Hispanic surgical residents a high-priority issue and, as a result, has formed a subcommittee on student mentoring. The goal of this subcommittee is to develop information for students in the seventh and eighth grades and beyond (when most young people begin to make general decisions about their future careers). The subcommittee also is creating informational material for teachers, counselors, and parents who need basic information on access to medical school and the opportunities in and the joys of careers in the health care professions, especially in surgery. The project aims to provide information to students, their families, and their counselors about college and medical school requirements and the curriculum that will prepare them for surgical education.

A day at the Congress

As a first small step in this process, the Graduate Medical Education Committee invited 150 students from inner-city Chicago public high schools to spend a day at last year's Clinical Congress. We also invited more than 50 African-American and Hispanic surgeons to serve as mentors for these students during the day. The Chicago Public School System welcomed this initiative from the College and directed us to an innovative program in place at 10 city schools—the Chicago Mathematics, Science, and Technology Academies (CMSTA). These “schools within schools” provide a curriculum strong in the



Robert Morris, MD, FACS (right), and his students.



Myriam Curet, MD, FACS (right), and one of her students.

sciences and mathematics, beginning in the seventh grade and continuing throughout high school. Students selected for the CMSTA program are

motivated, have good academic records, and possess an interest and an aptitude in science. Each CMSTA school sent 15 students and several of their



A participating student.



George Rawls, MD, FACS (right), and a student.

teachers and program coordinators to the Clinical Congress in October 2000. The Chicago public schools provided transportation and chaperones for the students, who started their day at the Clinical Congress at 7:30 am. Two or three students were then paired with each mentor and began a full day of exciting activities. After breakfast, the students and their mentors attended several scientific sessions and visited the exhibit hall. The exhibitors were uniformly welcoming and generous, and the students came away from the tours with real enthusiasm and many small gifts.

After lunch, James Rosser, MD, FACS, thrilled the crowd with a motivational rap performance complete with video and sound effects. The day concluded with a meeting with several of the medical students who were

attending the Congress through the annual Medical Student Program; these medical students told the high school students about their pathway to medicine and surgery. Several of the medical students come from similar inner-city backgrounds and related very well to the high school participants.

Plans for the future

The day was a great success. As the students' school year came to a close, we learned that the students were still talking about their experience at the Clinical Congress and that the CMSTA program has made medicine a focal point of their activities. Of course, we will not know for years whether this one day will encourage some of these bright and capable young men and women to select surgery as their ca-

reer. However, we are certain that each of them now knows that with hard work and dedication, becoming a surgeon is possible and rewarding. The role models they encountered—individuals who overcame many obstacles to become surgeons—were the key to the success of the day, and the committee is most grateful to them for their commitment to the careers of these students.

The program will be repeated during the 2001 Clinical Congress in New Orleans, LA, on Wednesday, October 10. Surgeons and surgery residents who are interested in participating as mentors are asked to contact Donna Coulombe at the College via e-mail at dcoulombe@facs.org, or call 312/202-5335.



ACS launches CME Joint Sponsorship Program

The Office of Continuing Medical Education of the American College of Surgeons has announced the launch of a CME Joint Sponsorship Program. The program will be conducted by the ACS as a national accrediting organization under the Accreditation Council for Continuing Medical Education and will offer cost-effective joint sponsorship to not-for-profit surgical organizations nationwide for the CME programs and meetings.

In the initial phase of the program, CME accreditation is being offered for meetings and educational programs scheduled to be held after July 1, 2001.

Further information and application materials are available from the program's administrator, Kathleen Goldsmith, at JSP@facs.org.

Chapter Leadership Conference:

Participants look to the future

by Diane S. Schneidman, Senior Editor

The future of the chapters was a central theme during the 2001 Chapter Leadership Conference, which took place May 17-18 at the College's headquarters in Chicago, IL. The meeting previously was known as the Chapter Officers Meeting; however, according to Rhonda Peebles, Manager of Chapter Services at the ACS, the name was changed this year to demonstrate that the program is intended for a range of participants, including chapter administrators.

George A. Parker, MD, FACS, Chair of the Governors' Committee on Chapter Activities, moderated the meeting. A total of 93 chapter officers, chapter administrators, and speakers attended. The program included reports from the College's executive staff, a discussion of legal issues, comments about strategic planning, four concurrent sessions, and a keynote address.

Keynote address

During the keynote address, Marilyn Moats Kennedy, founder of CareerStrategies, a consulting firm in Wilmette, IL, discussed the challenges associated with recruiting surgeons who were born after the "Baby Boom" and ensuring that they contribute to the chapters.

According to Kennedy, individuals born since 1965—"Baby Busters" or "Generation X"—

believe "associations must have a purpose other than just socializing." So, it is very important that organizations that want to increase their membership among young people focus on the mission of the organization, rather than networking prospects. In recruiting surgeons who are in their mid-30s and younger, chapter leaders need to "be authentic—be real," Kennedy added.

Further, chapters should bear in mind that members of this generation detest meetings, teamwork, and ongoing commitments. So, if an event doesn't capture their attention immediately and if an organization fails to make a good first impression, it is unlikely that these individuals will attend subsequent meetings or become active participants.

Busters keep tight reign over not only their time, but their money. They do not feel financially secure and are careful consumers. As a result, they tend not to give money to foundations. Their unwillingness to offer complete loyalty to an organization and to part with their money is the result of having seen "dad thrown away by General Motors like a used Kleenex," during the 1980s, Kennedy said. "This was a profound emotional experience."

The best means for communi-

cating with young potential members is via the Internet, Kennedy added. Busters spend two to three hours a day on the Web. To appeal to this audience, Web sites should describe the organization's mission, vision, unique qualities, and educational opportunities.

Strategic planning

The College and several ACS chapters have been engaging in strategic planning to help them respond to current challenges and prepare for the future. Michael Nussbaum, MD, FACS, President of the Ohio Chapter, shared his chapter's recent experience with strategic planning.

The chapter recruited a team of surgeons through its newsletter and hired a consultant to conduct the strategic planning process and to develop proposed initiatives. The panel determined that major challenges for the chapter were providing more educational opportunities for its members and advocating for its members and the patients they serve. They rewrote the chapter's mission statement to reflect these beliefs.

To carry out the objectives outlined in the mission statement, the chapter developed plans to, among other activities: hire a lobbyist, upgrade its Web site, heighten awareness

about the meaning of Fellowship, and increase representation on government advisory panels. The chapter's accomplishments as of press time included: cosponsoring a "legislative day" with the Ohio State Medical Association (OSMA), negotiating an agreement with OSMA for the provision of lobbying services, producing material on the meaning of Fellowship, developing a "members only" and a patient information section for the Web site, and publishing a new *Surgeon's Survival Manual*.

Thomas R. Russell, MD, FACS, Executive Director of the ACS, applauded the Ohio Chapter's efforts and noted that the College is "absolutely committed to helping the chapters."

Dr. Russell also spoke about the College's strategic planning initiative. "It's very important for an organization like this to step back and ask who we are and where are we going," he said. As a result, the College has examined all of the College's operations. This analysis has shown that the College is financially secure but could expand its efforts in a number of areas.

Hence, the College has launched a number of new initiatives and headed into new directions, Dr. Russell said. For example, the College is expanding its video- and Web-based educational offerings, developing "more collegial relationships" with other surgical and medical organizations, seeking novel ways to add value to Fellowship and member services, expanding its marketing programs, and strengthening its advocacy power.

Reports from executive staff

Harvey W. Bender, Jr., MD, FACS, ACS President, moderated a session featuring reports largely from the College's department directors. Highlights of their comments follow.

- Howard Tanzman, Director of the Information Services Department, noted that the chapter administrators have a special access number that allows them to get important contact information about Fellows through the College's online directory.

- Wendy Cowles Husser, Director of the *Journal of the American College of Surgeons* Department, noted that the *Journal's* Web site allows Fellows to test their knowledge and earn continuing medical education credits via the Internet.

- John P. Lynch, Director of the Organization Department, noted that the Governors have called for the College to establish a political action committee. At the time of the meeting, the Board of Regents were scheduled to discuss this possibility during their June 8-10 meeting.

- Karen S. Guice, MD, MPP, FACS, Director of the Fellowship Department, discussed the College's membership recruitment activities.

- Fred Holzrichter, Manager of the Development Office, spoke about the College's fundraising initiatives and goals.

- Linn Meyer, Director of the Communications Department, discussed the College's past advertising and marketing program and current efforts to enhance public education pertaining to surgical care.

- Olga Jonasson, MD, FACS, Director of the Education and Surgical Services Department, discussed the efforts carried out by the College's various educational committees.

- Jo Anne Sylvester, Associate Director of the Cancer Department, outlined the Commission on Cancer's organization and functions.

- Robert C. Mackersie, MD, FACS, a member of the ACS Committee on Trauma, spoke about the work of that body and its subcommittees and ad hoc panels.

- Cynthia A. Brown, Director of the Health Policy and Advocacy Department, explained that the Washington Office of the College is responsible for policy development, the analysis of legislative and regulatory issues, and coordination of the Fellows' advocacy efforts.

Legal issues

Paula Cozzi Goedert, an attorney with Jenner and Block, a law firm in Chicago, IL, discussed legal issues of concern to chapter leaders. Goedert said the best way for the chapters to avoid lawsuits is by regularly amending their bylaws to be reflective of their practices. "If you read and follow the bylaws, you'll be in good shape," she said. Although the risk of liability for chapters "is very small," it's still a good idea to carry liability insurance. "There is the occasional odd event that you need to have covered," she added.

Ms. Goedert also explained the reporting requirement for the chapters as tax-exempt organizations, distinguishing be-

tween taxable income and non-taxable income. For instance, she said that income in the form of corporate sponsorships is nontaxable income.

Concurrent workshops

The Chapter Leadership Conference featured two rounds of concurrent workshops. One session focused on the activities of four chapters. Rafael Zaragoz, MD, FACS, an ACS Governor, spoke about the Delaware Chapter's Volunteer Ambulatory Surgical Access Program (VASAP), which provides health care services to medically indigent individuals in the Philippines. Robert M. Quinlan, MD, FACS, Immediate Past-President of the Massachusetts Chapter, presented an overview of strategic planning activities, pointing out areas in which the College and

the chapters might join forces for their mutual benefit. Stephen R.T. Evans, MD, FACS, President-Elect of the Metropolitan Washington Chapter, described how the chapter's Young Surgeons Committee has added new life to the chapter through educational and social programs. Dr. Evans also explained how a new "development program" has stimulated corporate sponsorship of these events. Finally, Andrew W. Saxe, MD, FACS, President of the Michigan Chapter, discussed his chapter's involvement in the College's "Day in Surgery" program.

Another session focused on strategies for federal and state legislative involvement. During this session, Christian Shalgian, Government Affairs Associate, and Jon Sutton,

State Affairs Associate, both of the Health Policy and Advocacy Department, spoke to chapter officers about the legislative process and the making of "political insiders."

During another workshop, Robin Wright of Wright Communications in Evanston, IL, offered practical tips on giving an interesting speech and recruiting new members. Lastly, Gary Sigman, president of Blink Technology Corporation in Chicago, IL, provided an overview of Web site design and discussed the key principles of Web site architecture.

The College presents this meeting annually to help chapter leaders become acquainted with the services and programs available to chapters, the strategies other chapters have used to better serve their members, and the College's activities.

Committee on Trauma issues call for papers

Papers are now being accepted by the ACS Committee on Trauma, State and Provincial Chairs, for the 2002 Residents Trauma Papers Competition, which will take place April 8-11 during the committee's annual meeting.

The Residents Trauma Papers Competition is open to surgical residents and trauma fellows in the U.S., Canada, and Latin America. The papers should describe original research in the area of trauma care and/or pre-

vention categorized in either: (1) basic laboratory research, or (2) clinical investigation. Papers should be sent to the appropriate ACS state/provincial chair. If the chair is unknown, you may contact the ACS Trauma Department for that information.

Prize money will be awarded through the generosity of General Motors Research & Development, which has provided the ACS with a grant to promote trauma research. The papers competition is also funded by the

Eastern and Western States and Region VII Committees on Trauma.

Deadline for submission of papers to the state/provincial chair is November 15, 2001. Further information about the competition and obtained via the ACS Web site at <http://www.facs.org/dept/trauma/2002papers.html>, or by contacting the ACS Trauma Department, 633 N. Saint Clair St., Chicago, IL 60611-3211, tel. 312/202-5380.

No Second Opinion Needed.



The American College of Surgeons-Sponsored GoldSavers® Money Market From MBNA® America Bank

The ACS GoldSavers money market account with balances of \$50,000 has consistently outperformed more than 98% of money funds nationwide in 1999 and over 99% in 1998, according to IBC's *Money Market Insights*.*

With the added security of FDIC insurance up to \$100,000 per depositor, there's no second opinion required. Call today and compare. Minimum opening balance is \$2,500.

1-800-900-6653, ext. 6322

Monday through Friday, 8 a.m. to 8 p.m., and Saturday, 8 to 5 (Eastern time).



*December '99 and December '98 issues
GoldSavers®, MBNA®, and MBNA America are federally registered service marks of MBNA America Bank, N.A.
©2000 MBNA America Bank, N.A.



2002 surgical investigators conference will focus on NIH programs and policies

The Surgical Research Committee announces the sixth biennial Young Surgical Investigators Conference, to be held March 8-10, 2002, at the Lansdowne Resort & Conference Center, Leesburg, VA. The program includes: intensive exposure to National Institutes of Health (NIH) programs and

policies, information from NIH institutes, workshops in grantsmanship, and mock study sections with grant reviews. Many NIH staff participate in this conference, as do more than 50 senior surgeon-investigators. This conference is ideally suited for new faculty members who are inexperienced in grant-writing

and in applying for extramural research funds. Additional information and online registration are available on the College's Web site at <http://www.facs.org/dept/serd/srec/youngsurg.html>. The registration deadline for the Young Surgical Investigators Conference is January 2, 2002.

Surgeons As Educators course to be held in early 2002

The Graduate Medical Education Committee announces the ninth annual Surgeons As Educators course, February 23 through March 1, 2002, at the University of Florida Hotel and Conference Center, Gainesville.

The six-day course is limited to 30 participants and emphasizes the needs of adult learners

and the techniques necessary to develop an optimal learning environment for medical students, surgical residents, colleagues, and others in the health profession. The course will address teaching skills, curriculum development, educational administration and management, and performance

and program evaluation.

Information and online registration is available on the College's Web site at <http://www.facs.org/dept/serd/gmec/saeintro.html>. The registration deadline for this course is November 2, 2001.

PATIENT PRIVACY, from page 12

- sive Survey of State Health Privacy Statutes*. Washington, DC: Health Privacy Project, Georgetown University, August 1999. Web site <http://www.healthprivacy.org>.
2. Act 87, "Privacy of Health Care Information Act," State of Hawaii, 1999 legislative session (HB 351). Web site <http://www.capitol.hawaii.gov/>. Select "Archives," then "1999," then "List of All Acts under 1999 Legislative Session Bills Introduced, Passed, and Vetoes," then scroll down to Act 87.
 3. Altonn, H: Medical privacy law repeal criticized. *Honolulu Star-Bulletin* Online Edition, Sunday, April 29, 2001. Web site <http://starbulletin.com/>

2001/04/29/news/story7.html.

4. Rhode Island Confidentiality of Health Care Communications and Information Act, Section 5-37. Web site http://www.rilin.state.ri.us/gen_assembly/genmenu.html. Select "State of Rhode Island General Laws," then "5."
5. Wisconsin Annotated Statutes, Chapter 146. Web site <http://www.legis.state.wi.us/rsb/stats.html>. Enter in search box "ch.146" and press "Go."
6. American College of Surgeons: Comments on standards for privacy of individually identifiable health information. Unpublished letter to HHS, March 30, 2001.

The *Journal* page

Message from the Editor

by Seymour I. Schwartz, MD, FACS, Rochester, NY

The article by Drs. Joseph Fortner and Leslie Blumgart entitled "A Historical Perspective of Liver Surgery for Tumors at the End of the Millennium" appearing in the August issue of the *Journal of the American College of Surgeons* is particularly meaningful for me because I have witnessed the birth and participated in the development of modern hepatic surgery.

It was in 1952, during the second year of my residence, that Lortat-Jacob and Robert's report on the controlled resection of the right lobe of the liver was published. It was in 1981 that Professor Couinaud published his work that defined the segmental anatomy of the liver, thereby opening the door for segmental resection. In the 1980s, the technical refinements of intraoperative ultrasonography and ultrasonic dissection were ap-

plied. Thus, during my surgical lifetime, the field of hepatic resection has undergone explosive expansion coupled with increased safety.

This development is emblematic of the advances in surgery that have occurred over the last half of the 20th century. We are told that the doubling time for scientific knowledge is now only four years, which translates into rapid evolution of many aspects of surgery. Clearly, our current golden age is being supplanted by one of an even more precious metal.

Dr. Schwartz is Distinguished Alumni Professor, University of Rochester (NY) School of Medicine and Dentistry. He is also Editor-in-Chief of the Journal of the American College of Surgeons and a Past-President of the College.

INTRODUCTORY ABSTRACT from the August lead article

Surgeons and Injury Prevention: What You Don't Know Can Hurt You! M Margaret Knudson, MD, FACS, Mary J Vassar, MS, Erica M Straus, BA, Jeffrey S Hammond, MD, MPH, FACS, Sylvia D Campbell, MD, FACS. From the San Francisco Injury Center, University of California, San Francisco (Knudson, Vassar, Straus) and the Subcommittee on Injury Prevention and Control, American College of Surgeons Committee on Trauma (Knudson, Hammond, Campbell).

Background: The most effective treatment for traumatic injuries is to prevent them from occurring. Currently, few surgeons receive any formal training in injury control and prevention. This study was designed to test the knowledge of injury prevention principles among practicing surgeons, in order to identify areas in need of intensified educational efforts.

Study design: Survey questions designed by members of the American College of Surgeons Committee on Trauma were programmed into a specialized touch-screen computer, which was displayed at four

different surgery or trauma meetings, including the ACS Clinical Congress in 1999 and 2000. Participants were questioned about their knowledge of trauma epidemiology, bicycle helmet effectiveness, child safety seat usage, suicide, and domestic violence.

Results: Seventy-nine surveys were completed by surgeons, including 33 specializing in trauma care, and by 106 nurses attending trauma courses. Overall, the percentage of correct answers was 50%. There were no significant differences in survey scores between trauma surgeons versus general surgeons, although both scored higher than trauma nurses. Areas where knowledge deficits were the most apparent included the proper use of child safety seats, the effectiveness of airbags, the prevalence of suicide, and the annual cost of injury in America.

Conclusions: The majority of practicing surgeons and nurses, including those working at trauma centers, are unaware of the basic concepts of injury prevention. Advancements in the field of injury control will require efforts to educate medical professionals and the public.